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ABSTRACT

This manual for the school health programs in New Mexico contains a composite of procedures used in school health services, healthful school environment maintenance, and health science instruction. These procedures are used by physicians, dentists, nurses, teachers, etc. to appraise, protect, and promote optimum health of students and school personnel. It is also designed to improve the school environment which combines physical, social, and emotional factors of the school setting that affect the health, comfort and performance of an individual or group. Comprehensive descriptions and discussions cover: (1) the functions and operations of the New Mexico health program; (2) the major responsibilities in the school health program; (3) school health services; and (4) health screening protocols. The appendices are comprised of: (1) health manuals; (2) school health job descriptions; (3) contact persons; and (4) sample forms used in the health program. (JD)

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NEW MEXICO

School Health MANUAL

FOR ELEMENTARY AND SECONDARY SCHOOLS

1986

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NEW MEXICO
SCHOOL HEALTH MANUAL
FOR ELEMENTARY AND SECONDARY SCHOOLS
1986

Alan D. Morgan
State Superintendent of Public Instruction

Prepared by

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The School Nursing Advisory Committee (SNAC) undertook the task of reviewing and revising the School Health Manual. The committee members looked at specific areas of School Health Services and worked with local and state health consultants to make each section of the School Health Manual meaningful to local school personnel, particularly school nurses.

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The Advisory Committee expresses its appreciation to members and to the Health consultants for their contribution to the revision of the School Health Manual.

SCHOOL HEALTH MANUAL

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CHAPTER I

OVERVIEW OF THE SCHOOL HEALTH PROGRAM

"Health is a basic and major objective of education and is fundamental to the present and future welfare of the nation. A student's physical, mental, emotional, and social health directly affects the quantity and quality of learning."

Definitions and Philosophy

The "school health program" is the composite of procedures used in school health services, healthful school environment, and health science instruction to promote health among students and school personnel.

"School health services" are the procedures used by physicians, dentists, nurses, teachers, etc., designed to appraise, protect, and promote optimum health of students and school personnel.

"School health education" is the process of providing or utilizing experiences for favorably influencing understandings, attitudes, and practices relating to individual, family, and community health.

"Healthful school environment" is the combination of physical, social, and emotional factors of the school setting which affects the health, comfort, and performance of an individual or group.

Parents have the primary responsibility for the health of their children. However, the school is in a strategic position to supplement the efforts of parents in this respect. Also, since the law compels children under a certain age to attend school, the school must assume at least part of the responsibility for protecting the health and safety of the child while in school.

The health of the school child is dependent on many things: the health status of the family, the condition at birth, the health supervision received as an infant and preschool child, and the overall health status of environment and community. The successful school health program requires the active cooperation of many people, both in the school and in the community. The family, the family health providers, school nurse, and other school personnel, the health department, the voluntary health agencies, and other interested groups must all work together if a good school health program is to be achieved.

Functions of the Local School Health Committee/Advisory Committee

A. To coordinate the school's existing school health program, including health services, health education, and healthful school environment both within the school and between the school and community.

B. To find and study problems in these three health areas.

C. To determine resources available for solving problems.

D. To suggest solutions for problems.

E. To initiate a program looking toward the professional growth of all staff members in the field of school health.

Organization and Operation of the School Health Committee/Advisory Committee

A. Personnel

The membership of the School Health Committee should include members from all organizations interested in student health.

B. Suggested Operational Steps

1. Organize. Anyone can initiate this first step.
2. Conduct a local survey to assess health problems and needs.
3. Determine priorities for problems and needs found.
4. Determine local and state resources.
5. Make recommendations for action.
6. Follow up on recommendations.
7. Evaluate periodically the council's activities, progress, and methods.

C. Task Forces

Working committees or task forces should be set up for each one of the areas: health services, health education, and healthful school environment. All committee meetings should be kept as informal as possible. Committees should be formed only as needed, and then disbanded as soon as their assignments are completed.

D. Policies

All persons affected by school health policies ought to have the opportunity to assist in the formulation of school health policies. The committee should be a policy-deliberation body and should make recommendations concerning policy adoption. The responsibility of translating policy into action falls on the school administration.

Program Evaluation

The good school health program is dynamic, and dynamic programs must constantly adjust to changing needs. Therefore, in order to maintain a high level of effectiveness, both specific and overall aspects of the school health program need to be evaluated frequently.

1. **Observations.** This is the most frequently used method in all school appraisals and can be done by all school personnel. Types of behavior and general physical appearance are important as indications of health needs which might necessitate changes in the health program.

2. **Interviews and Conferences.** Such informal meetings often reveal facts not obtained in other ways.

3. **Self-Appraisals.** Analyzing one's own health habits and practices in writing is a device that is particularly helpful. It also may help in planning health instruction and other phases of the school health program.

4. **Questionnaires.** These are most commonly used in obtaining information on health practices, attitudes, knowledge, and health problems that are of great concern to the community. Health interest inventories are also helpful in planning health instruction.

5. **Checklists.** These are usually found to be most valuable in surveying physical health facilities or sanitary conditions.

6. **Surveys.** These can combine several of the methods herein described in evaluating health projects, conditions, or situations.

7. **Records.** Good school health records can be a most valuable source of information for program planning. In addition to family and personal health records, absence and accident records can be of particular significance in helping to evaluate both school health policies and programs.

8. **Tests.** These provide partial information concerning the effectiveness of health instruction.

Evaluation of the total school health program is important and should be done regularly. It is recommended that a school health evaluation be done under the leadership of the school administration. The State Department of Education evaluates the program through the Educational Standards.

CHAPTER II

MAJOR RESPONSIBILITIES IN THE SCHOOL HEALTH PROGRAM

The following responsibilities are recommended.

Health of School Personnel

The physical and emotional health of all the school personnel is very important in producing a healthful school environment. All personnel should be free from serious communicable disease. Serious emotional problems of the staff also prove to be dangerously communicable, and affect the mental health and morale of other staff members and of pupils. Staff members with symptoms of emotional disturbance should be assisted in a sympathetic way to seek professional help. Employee health programs are encouraged, especially those that address stress management, nutrition, exercise, environmental health, consumerism, and wellness.

Health Duties of School Personnel

1. **Board of Education**

   The board of education assumes responsibility for the overall health program, budget, facilities, planning, and personnel.

2. **Administrator**

   The administrator provides the opportunity for self evaluation of school personnel in dealing with human relation problems, assessment of health needs, and providing a vehicle by which school health policies, personnel directives, and regulations may be developed and implemented.

   Rest periods, convenient and environmentally safe lounges, and the opportunity of meetings and discussions with other teachers and administrators are features of a school program that are important to the teachers' mental health. An effective plan worked out by each school system protects the health of school personnel (including the principal, teacher, nurse, clerk, school lunch worker, bus driver, etc.) and of the children with whom they come in contact.

   a. The administrator furnishes leadership for all phases of the school health program including the development of policies needed for adequate maintenance of the program. (Reference: The New Mexico Board of Education's Educational Standards for New Mexico Schools, 7.3 Health Services Program.)

   b. The administrator assumes responsibility for seeing that all children and employees under his or her jurisdiction have complied with state laws and regulations relating to immunization and health examinations of school personnel.

   c. The administrator operates the school plant in accordance with all current codes and regulations governing school construction, sanitation, safety, and fire protection.

   c. The administrator assures that an adequate number of school personnel in each school building have current first-aid training and assigns a sponsoring teacher with CPR certification responsibility of first-aid on field trips.

3. School Nurse

The nurse who works in the school setting focuses on the goals and philosophy of the educational program offered. The population to be served might include children of all ages with a variety of needs. In addition, the nurse serves the adults in the work setting as well as the families of school children. The promotion and maintenance of good health is becoming increasingly important and requires that nurses become more involved in prevention programs which address students, staff, families, and the community. Prevention is organized into these general frameworks:

a. Primary prevention. Prevention of disease which includes health promotion and avoidance activities that keep individuals functioning in a healthy way.

b. Secondary prevention. Some disease or dysfunction exists, but disability or severe sequelae are prevented by early diagnosis and early treatment.

c. Tertiary prevention. Disease or disability is present and activities are focused on rehabilitation and/or minimizing dysfunction to the degree possible.

School nurses have an important role to play in developing programs which address all three aspects of prevention.

School nursing encompasses a great many areas of health knowledge and medicine. It becomes overwhelming when one considers all the potential activities that are appropriate and possible within a school health program. Each nurse must consider the needs of students, staff, families, and community when working with other school personnel to develop a meaningful health program.

The following goals should be considered when developing a school nursing role within the school setting:

a. To act as an advocate for the health rights and needs of children and their families both within the school setting and between the school and community at large.

b. To deliver needed health services to the client system using systematic processes to assess needs, plan interventions, and evaluate outcomes so that high-level wellness can be achieved.

c. To provide health counseling and guidance for the client system on an individual basis or within a group setting.

d. To participate in health education program activities for children, youth, school personnel, and the community.

e. To participate in planning, implementation, and evaluation of a school health program.

Susan Wold, School Nursing, A Framework for Practice. CV Mosby Co., 1981.

3. School Nurse, Continued

The nurse, who is administratively responsible to the school principal when working in the school, plays an important part in all phases of the school health program, including health services, health instruction, and the healthful school environment. The school nurse assists in projects for protecting or improving community health practices, and the promotion of health programs in grades K-12. The school nurse also helps in planning the budget for school health services.

The nurse promotes medical and dental care of all school children. The nurse encourages parents of elementary school children to be present at the medical and dental examinations, and helps them plan ways of securing the care recommended. The nurse also assists in the promotion of health for all members of the school child's family since he or she learns to know these families well through parent conferences as well as home visits. The nurse is, therefore, in an excellent position to act as liaison between school and home. The school nurse interprets the conditions in the home to the school personnel and parents understand the health services and policies of the school. The nurse is responsible for follow up of children with specific health problems.

The nurse also has the responsibility of coordinating all available information on the health status of each child by keeping the health record up to date, and by providing teachers, parents, physicians, dentists, and community agencies with reports as indicated. The nurse also assists in the modification of the school program to meet the needs of the handicapped child.

The nurse acts as consultant and advisor to the teacher who gives the actual classroom instruction in health. The nurse maintains contact with the local and state Health and Environment and Human Services Departments freely utilizing their consultant services. (See the job description in Appendix B.)

4. **School Health Aides**

A school health aide is a paraprofessional employed to release school nurses from nonprofessional school health functions so they may have more time and opportunities to use their professional nursing skills in the school health program. The school health aide performs health program related work as assigned by the school nurse. (See the job description in Appendix B.)

5. **District Health Officers**

As noted in New Mexico State Statutes: "All school health personnel, except physical education personnel, are under the direct supervision and control of the district health officer in their district. They shall make such reports relating to public health as the district health officer in their district requires." (24-1-4)

The local health officers will provide direct supervision and control of the following functions:

a. Activities requiring medical authorization from the district health officers; e.g., immunizations, controlling communicable and nuisance diseases.

b. Activities involving professional nursing skills; e.g., assisting with health examinations, interpreting medical orders and findings during follow-up.

c. Activities in which the school nurses' services are deemed necessary by the district health officer in helping the health department to conduct community or public health programs involving school-aged children; e.g., immunization clinics.

d. Activities involved in the follow-up of the child with health problems.

e. Annually review, write, and sign standing orders for all school nurses in the Health District. Specific conditions which may be included in the standing orders could include: body and head lice, scalries impetigo, tinea pidis, tinea carporis, tinea capitis, and the emergency protocols from the HSD immunization protocol book.

f. Periodically provide information to school nurses concerning changes and/or updates on school health issues.

g. Promoting wellness concepts, as they evolve, through the schools.

The major part of the school nurses' functions are "school health program" functions, and except for the functions requiring professional nursing skills and medical authorization, these will be guided on a joint basis by the New Mexico Health and Environment Department and the State Department of Education, in cooperation with district health officers and local school administrators.

6. **Teacher (Elementary and Secondary)**

   a. The teacher makes informal observations throughout the day to detect suspected deviations from the usual health status of each pupil and reports such deviations to the principal and school nurse.

   b. The teacher incorporates and coordinates health education in all phases of the school health program, in addition to incidental teaching, correlation with other subjects, and integration.

   c. The teacher assists in maintaining a classroom that will promote healthful living and helps pupils assume their responsibility for maintaining a healthful and safe environment.

   d. The teacher ensures that pupils receive first aid in emergency situations.

   e. The teacher encourages pupils to evaluate their own health and health behavior and to take responsibility for improvement.

   f. As a role model, the teacher sets a good example in terms of desirable health habits, attitudes, and practices.

   g. The teacher adjusts pupils' programs, when needed, to accommodate for health handicaps.

   h. The teacher understands the relationship of the total school program to the demands made on the time and energy of pupils and cooperates in planning a balanced curriculum which contributes to, rather than undermines, pupil health.

7. **Guidance Counselor**

   a. The guidance counselor provides individual and group opportunities to promote emotional and social health; personal growth and self-understanding; as well as to teach problem-solving and decision-making skills.

   b. The guidance counselor identifies students who have emotional and behavior disturbances and cooperates with staff and support personnel in assessing those students and in helping their families find help through school and community resources.

   c. The guidance counselor serves as a resource person to the staff for the planning of in-service, the development of curricula, and the identification of alternatives available to serve students.

   d. The guidance counselor makes known to the teacher, administrator, nurse, parent, or other appropriate people, the health needs of pupils seen in counseling.

   e. The guidance counselor maintains case records which include pertinent health information.

8. **Lunchroom Manager**

The lunchroom manager assists the administrator in the organization of the school lunch program and assumes responsibility for its operation to provide nutritious meals to children. These meals are designed to meet the nutritional needs of children for one or two meals of the day and by example encourage children to eat a balanced diet. The lunchroom manager may offer information on the nutritional requirements of the school lunch program to administration and faculty.

School Health Services

School health services are designed to protect the health of each pupil and to enable each one to attain the maximum possible state of well-being. They include the determination of health needs, follow up and interpretation, care of emergency sickness and injury, and the prevention and control of communicable disease. The manner in which these services are provided must of necessity be adapted to the local community. Since the school will expect a child to begin kindergarten in as good health as possible, parents should be urged to seek health care for their preschool children, either through their family physician or at a local health clinic.

In the determination of health needs, the usual sources of information are: the history given by the parents regarding the physical, mental, and emotional condition of the child; the medical and dental examinations, including the nutritional status; continuous observation by teachers; and physical assessments or screening tests done by the school nurse.

CHAPTER III

SCHOOL HEALTH SERVICES

HEALTH PROMOTION/WELLNESS

Those involved in education have a clear obligation to promote health and wellness and not merely to prevent disease or disability.

Ardell defines wellness as a conscious and deliberate approach to an advanced state of physical and psychological/spiritual health. This is a dynamic or ever changing, fluctuating state of being. (Ardell, The History and Future of Wellness, 1984.)

Lifelong wellness depends very much upon well adults. Children depend upon them for appropriate wellness instruction and for appealing and persuasive wellness models. (Pilch, Wellness, 1981.)

The school nurse must be willing and able to move from the illness model to a health promotion/wellness model emphasizing Ardell's five dimensions of high level wellness by promoting:

1. Self-responsibility in health maintenance and wellness;
2. Physical fitness for all students;
3. Nutrition awareness and alternatives to unsound nutritional practices;
4. Environmental sensitivity and responsibility; and
5. Stress awareness and stress management.

Wellness is the integration of body, mind, and spirit -- the appreciation that everything you do, and think, and feel, and believe has an impact on your state of health. (Ryan and Travis, The Wellness Workbook, 1981.)

HEALTH HISTORY

The health history (see Appendix D) given by the parent should include diseases the child has had, immunizations the child has received, data on serious operations, disabling accidents, comments on eating habits, allergies, behavior disturbances, emotional problems, and other potentially handicapping conditions. The history obtained from the parent should be recorded on a cumulative health record which should accompany the child through his or her school life. On it are recorded, in addition, significant information obtained from teacher observations, parents, results of screening tests, physician's and dentist's findings, and all other information bearing on the child's mental as well as physical health, particularly such problems as diabetes and epilepsy, sensory or musculoskeletal handicap, or cardiac or respiratory difficulties which might require modification of the school program for a pupil.

Health records are of value only to the extent of (1) the accuracy of content and (2) their optimum use. The school nurse and teachers should study the health records of their pupils before the school term begins, noting any conditions for which action or planning is indicated, especially conditions that may create a classroom emergency. The school nurse should interpret the health information to the teacher and other school personnel as indicated in order to give them a better understanding of their students. Immunization records must indicate specific dates for all required immunizations.

The school health record (see Appendix D) approved by the New Mexico Department of Education provides space for the health history and additional health information. It is important that school personnel understand the confidential nature of the school health record. Written policies should govern who may see the records and where and how they should be filed. Information should not be released to outside agencies or individuals without written consent of the pupil's parents.

The administrator responsible for health services should determine with the health staff how records are to be used and who is responsible for recording data and keeping records up to date. The school nurse is usually responsible for maintaining the health records. Sometimes, for special reasons or in certain cases, the school nurse and physician may feel it necessary to establish an additional file for data which they do not consider appropriate for inclusion in the child's regular health record. This will usually be necessary for safeguarding intimate details of the family history and some kinds of problems in the child.

MEDICAL EXAMINATIONS

The purpose of periodic medical examinations is to detect important health problems and ensure that they are remedied. In general, periodic physical examinations of well school-aged children seldom reveal significant health problems because (1) the child is usually well at the time of the examination; (2) most medically important conditions have usually been identified in prior examinations; and (3) the prevalence of morbidity and mortality in this age group is low. However, certain subpopulations of children may be at higher risk for health problems. These subpopulations include children from low socioeconomic families, children with poor school performance, existing handicaps, frequent absences, and disciplinary problems.

School physical examinations should optimally be performed by the family's private physician where past association with the child will facilitate a complete assessment. If such an individual is not available, then other arrangements should be made with other community providers. The least desirable is via mass examination when large numbers of children are seen.

The parents of elementary school children should be present during the medical examination in order to be ready to elaborate on the health history of their child, and so that the physician can discuss and interpret any recommendations that may be made. Adolescents, on the other hand, should be encouraged to assume more responsibility for their own health problems if the parent is present.

The school nurse's role should be one of triage and referral. School nurses do not conduct complete physical examinations but should identify children with suspected or proven medical conditions and refer them to appropriate providers. They should provide patient related history and conduct follow-up when necessary.

The order of priority for medical assessments should be (1) children identified as having problems either by history, observation, or screening tests (both their initial referral and the continued monitoring of their treatment); (b) children entering school; (c) children in mid-school (grade 6 on); and (d) adolescents prior to leaving school (grade 11 or 12). Candidates for school athletics must have, in addition, a medical examination each year before engaging in sports to determine physical fitness for a particular activity. Such examinations for athletes are required of all schools belonging to the New Mexico Activities Association. Athletes who become seriously ill or injured during the sports season should not be allowed to return to the sport until approval is given by the attending physician. Psychological examinations also are used for periodic appraisals and for evaluations of special referrals. The examinations should be conducted by a qualified clinical psychologist or psychiatrist.

DENTAL HEALTH

Tooth decay and peridontal disease, although not usually life-endangering, are a leading cause of morbidity in school children. Most dental disease is preventable. School settings are valuable for programs that help prevent tooth decay because this disease is especially prevalent in youth and adolescence. Prevention of dental disease is enhanced in the following ways:

1. **Fluoride.** Increased encounters with fluorides in the diet and in health care products may be decreasing the prevalence of tooth decay in most countries throughout the world. Ways in which teeth may benefit from fluoride include:

   a. Water fluoridation. Tooth decay can be prevented substantially by the proper amount of fluoride in the drinking water, especially during the first 21 years of life.

   b. Toothpaste. School children should be encouraged to use an American Dental Association approved fluoride toothpaste.

   c. Fluoride mouth rinse. New tooth decay can be reduced by up to 50% by a once-a-week fluoride mouth rinse program. Even if drinking water already has fluoride added to it, a fluoride mouth rinse program will give added protection against cavities with no harm.

2. **Sealants.** Coating the rough biting surfaces of the permanent back teeth with a plastic film provides additional protection against decay for the part of the tooth that is protected least by fluoride.

3. **Oral Hygiene.** Developing proper lifelong personal home dental care habits is good insurance against excessive dental disease. Oral health care instruction is desirable, but some studies have suggested that oral health education alone may not significantly reduce dental disease in school children.

4. **Nutrition.** Nutrition guidelines for dental health are the same as those for good general health. A direct causal relationship has been established between the use of refined carbohydrates and dental disease. The frequency of exposure of teeth to sweets during a given period is more important than total sweets consumed during that time. Therefore:

   a. Students should not be allowed to consume sweet snacks or chew sugared gum during classes.

   b. Use of vending machines or other sale of candy, pastry, or sweetened beverages should be limited to a period immediately following lunch, since sweets consumed with a meal are less harmful to teeth than between meal sweet snacks. Limited opportunities should be available to consume snacks later on that have been saved from the lunch period.

   c. Alternatives to sweet snacks should be available. (A popcorn machine is often a money maker for school projects.)

5. **Accidents and Accident Prevention.** If a tooth should be avulsed (knocked out) on the school grounds, it should be reinserted immediately or saved for possible reimplantation. Gently rinse away any dirt and place the tooth in the socket. Transport the child to a dentist as soon as possible. If the tooth is not put back in the socket, place it in milk. Take the child and the tooth to the dentist as soon as possible. Mouth guards should be worn by students engaging in contact sports to prevent injuries to the mouth and teeth.

Dental Infections

A child with an acute dental infection does not belong in the classroom. Special precautions for protecting other children when a classmate has a dental infection are not usually necessary. However, in questionable cases, the dentist should be consulted.

Excuses from School for Dental Care

Dentistry for children often demands extra time and effort and should not be restricted to after school hours, when both the child and dentist are tired. A dental appointment can be a direct individualized learning experience which will often provide values which could not be learned in the classroom. A school policy should be established to verify the legitimacy of dental appointments.

Dental Examinations

Routine regular dental examinations by the family dentist provide the best means of preventing toothaches and for arresting the progress of dental disease. School systems should encourage annual dental examinations by the family dentist.

Dental Case Finding (Screening)

If dental screening is desired in the schools, contact the State Department of Health and Environment, the local health district office, and/or local dental resources for program guidelines.

NUTRITION

Children suspected of having poor nutrition as evidenced by poor growth and development (stunting, underweight, overweight), inattentiveness in classes, advanced dental disease, or obviously poor nutritional practices should be referred to the school nurse for initial nutritional screening. A 24-hour diet recall should be taken (see Appendix D) to evaluate approximate nutrient intake. The student's height and weight should be measured and plotted on the appropriate growth chart (see Appendix D). Problems with nutrient intake or inappropriate growth patterns should be counseled on according to the following guidelines:

- Eat a variety of foods from all the food groups.
- Maintain ideal weight; balance food intake with regular exercise.
- Eat foods with adequate starch and fiber, particularly vegetables, whole grain products, and fruits.
- Avoid too much sugar, fat, or sodium.

Use nutrition education handouts and resource guides to aid in student education (see Appendix D). In some cases a referral to a dietitian/nutritionist or physician may be appropriate. Nurses trained in nutrition may select to undertake basic nutrition counseling with children and their parents as long as medical conditions do not exist which would require therapeutic diet counseling.

Eating disorders -- anorexia nervosa and bulimia or a combination of the two -- are prevalent among the adolescent population. These conditions which may be detected through diet related discussions are serious and students with an eating disorder need to be referred for professional psychological, nutritional, and medical assistance. Students should also be given a list of organizations concerned with aiding people who have eating disorders (see Appendix).

School nurses should take an active leadership role in promoting the use of nutritious foods at all school functions and in school facilities. These include snacks for the following:

1. Kindergarten children.
2. School parties.
3. Athletic and social events.
4. Vending machines.

See Appendix for a Snack Sheet reference.

School nurses can have an important impact on students as a role model for healthy eating and exercise habits. The key to a healthy nutrition lifestyle is moderation, a variety of eating, and regular exercise.

For further nutrition information, or if you have questions, call or write: Nutrition Section, Health Services Division, P.O. Box 968, Santa Fe, New Mexico 87504-0968.

TEACHER OBSERVATIONS

Teachers are in a strategic position to notice changes in appearance and behavior that are indicative of changes in health status. Their day-to-day contact with their pupils gives them an opportunity to detect deviation in the health of individual children which might go unnoticed by others, even the child's parents. Teachers should be alert throughout the day for signs of health deviations in pupils.

The teacher is able to evaluate the children in relation to their past history and progress in relation to their peers. The teacher is not asked to make a diagnosis, but to refer to the nurse those pupils whom he/she feels are not doing as well, in terms of health status, as they should. Since health status may change abruptly, the fact that a child has had a recent medical examination or had recently been in good health should not deter a teacher from referring a child if he/she thinks it is indicated. A teacher can rapidly become a skilled observer of a child's health status. Opportunities for teachers to improve their observational skills should be provided.

As a guide to the teacher and other school personnel, the following conditions which usually indicate a need for referral to the school nurse or other designated person are listed:

- Frequent absence;
- Inattention or listlessness;
- Tiredness or breathlessness;
- Over-aggressiveness or shyness;
- Fidgeting (especially in a previously placid child);
- Stuttering or other speech problem;
- Skin eruptions;
- Frequent nosebleeds;
- Inability to keep up with the class;
- Frequent crying, worrying, lying, stealing, bullying, fear, or other evidences of emotional disturbances;
- Abnormal weight deviations, rapid changes in weight or poorly nourished children.

Such types of behavior should be evaluated in their proper perspective before the decision is made to refer the child; i.e., does the symptom occur for a prolonged period, does it deviate in an excessive degree from what other children show or from the usual pattern of behavior or health status?

CHILD ABUSE AND NEGLECT

Child abuse and neglect (maltreatment) are serious and widespread problems. It is estimated that in the United States more than one million children are victims of physical abuse or neglect each year and at least 2,000 die annually from circumstances associated with abuse or neglect. There has been a tremendous increase in the number of reported cases in the nation over the past several years. Statistics show that nationwide, as well as in New Mexico, the largest number of referrals on child maltreatment come from the schools. The school nurse should play a key role in the identification of child maltreatment because of his/her professional ability to evaluate medical as well as behavioral indicators that may be affecting the well-being of the child.

The following information is taken from the New Mexico Children's Code (New Mexico State Statute 30-6-1), the law in regard to abuse and neglect:

A. Any licensed physician, resident, or intern examining, attending, or treating a child, any law enforcement officer, **registered nurse,** visiting nurse, **school teacher,** or social worker acting in his/her official capacity, or any other person **knowing or suspecting** that a child is an abused or neglected child, shall report the matter immediately to:

    1. The criminal prosecution division of the office of the district attorney; or
    2. The county social services office of the human services department in the county where the child resides; or
    3. The probation services office of the judicial district in which the child resides; or
    4. The toll-free child abuse hot line, 1-800-348-3456.

B. Definitions:

    1. A "child" is an individual who is less than 18 years old.

    2. A "neglected child or abused child" means a child:

        a. Who has been abandoned by his/her parents, guardian or custodian; or
        b. Who is without proper parental care and control or subsistence, education, medical, or other care or control necessary for his/her well-being because of the faults or habits of his/her parents, guardian, or his/her neglect or refusal, when able to do so to provide them; or
        c. Whose parents, guardian, or custodian is unable to discharge his/her responsibilities to and for the child because of incarceration, hospitalization, or other physical or mental incapacity; or
        d. Who has been placed for care or adoption in violation of the law; or
        e. Who has been physically, emotionally, psychologically, or sexually abused by his/her parent, guardian, or custodian; or

B. 2. f. Who has been sexually exploited by his/her parent, guardian, or custodian; or
    g. Whose parent, guardian, or custodian has knowingly, intentionally, or negligently:
        1) Placed the child in a situation that may endanger his/her life or health; or
        2) Tortured, cruelly confined, or cruelly punished him/her.

C. Immunity

Anyone reporting an instance of alleged child abuse or neglect or participating in a judicial proceeding brought as a result of a report is presumed to be acting in good faith and shall be immune from liability, civil or criminal, that might otherwise be incurred or imposed by law unless the person acted in bad faith or with malicious purpose.

Physical and Behavioral Indicators

The following is a list of physical and behavioral indicators of child abuse and neglect:

A. Physical Indicators of Physical Abuse

1. Unexplained bruises and welts:

    a. On the face, lips, mouth, torso, back, buttocks, thighs;
    b. In various stages of healing;
    c. Clustered, forming regular patterns reflecting shape of the article used to inflict (electric cord, belt buckle);
    d. On several different surface areas;
    e. Regularly appearing after absence, weekend, or vacation.

2. Unexplained burns such as:

    a. Cigar or cigarette burns especially on the soles, palms, back, or buttocks;
    b. Immersion burns (sock-like, glove-like, doughnut shaped on buttocks or genitalia);
    c. Patterns like electric burner, iron, etc.;
    d. Rope burns on arms, legs, neck, or torso;
    e. Infected burns indicating delay in seeking treatment.

3. Unexplained fractures/dislocations:

    a. To the skull nose, or facial structure;
    b. In various stages of healing;
    c. Multiple or spiral fractures.

4. Unexplained lacerations or abrasions to the mouth, lips, gums, eyes, or external genitalia in various stages of healing.

5. Bald patches on the scalp.

B. Behavioral Indicators of Physical Abuse

1. Feels deserving of punishment.
2. Wary of adult contact.
3. Apprehensive when other children cry.
4. Behavioral extremes; aggressiveness or withdrawal.
5. Frightened of parents.
6. Afraid to go home.
7. Reports injury by parents.
8. Vacant or frozen stare.
9. Lies very still while surveying (infants).
10. Responds to questions in monosyllables.
11. Inappropriate or precocious maturity.
12. Manipulative behavior to get attention.
13. Capable of only superficial relationships.
14. Indiscriminately seeks affection.
15. Poor self-concept.

C. Physical Indicators of Physical Neglect

1. Underweight, poor growth pattern; e.g., small in stature, failure to thrive.
2. Consistent hunger, poor hygiene, inappropriate dress.
3. Consistent lack of supervision, especially in dangerous activities or for long periods.
4. Wasting of subcutaneous tissue.
5. Unattended physical problems or medical needs.
6. Abandonment.
7. Abdominal distention.
8. Bald patches on the scalp.

D. Behavioral Indicators of Physical Neglect

1. Begging or stealing food.
2. Extended stays at school (early arrival or late departure).
3. Rare attendance at school.
4. Constant fatigue, listlessness, or falling asleep in class.
5. Delayed speech.
6. Inappropriate seeking of affection.
7. Doesn't change expression.
8. Assuming adult responsibilities and concerns.
9. Alcohol or drug abuse.
10. Talks in a whisper or whine.
11. Delinquency (e.g., thefts).
12. States there is no caretaker.

E. Physical Indicators of Sexual Abuse

1. Difficulty in walking or sitting.
2. Torn, stained, or bloody underclothing.
3. Pain, swelling, or itching in genital area.
4. Pain on urination.
5. Bruises, bleeding, or lacerations in external genitalia, vaginal, or anal areas.
6. Vaginal/penile discharge and/or odor.
7. Venereal disease, especially in pre-teens.
8. Poor sphincter tone.
9. Pregnancy.

F. Behavioral Indicators of Sexual Abuse

1. Unwilling to change for gym or participate in physical education class.
2. Withdrawal, fantasy, or infantile behavior.
3. Bizarre, sophisticated, or unusual sexual behavior or knowledge.
4. Poor peer relationships.
5. Delinquency or runaway.
6. Reports sexual assault by caretaker.
7. Change in performance in school.

G. Physical Indicators of Emotional Maltreatment

1. Speech disorders.
2. Lags in physical development.
3. Failure to thrive.
4. Hyperactive/disruptive behavior.
5. Sallow, empty facial appearance.

H. Behavioral Indicators of Emotional Maltreatment

1. Habit disorders such as sucking, biting, rocking.
2. Conduct/learning disorder; antisocial behavior, destructive.
3. Neurotic traits; sleep disorders, inhibition of play, unusual fearfulness.
4. Behavioral extremes; child does not change expression, complains, passive, aggressive, demanding.
5. Overly adaptive behavior; inappropriately adult, inappropriately infantile.
6. Developmental lags; mental or emotional.
7. Attempted suicide.

The presence of one of the above indicators does not necessarily mean that a child is abused or neglected; however, the presence of more than one indicator or an indicator combined with other information should warrant further assessment by child protective service personnel. In New Mexico, the Human Services Department of the Social Services Division investigates all reports of child abuse or neglect. More information may be obtained by contacting the Social Services Division office in the county in which the child resides or by using the toll free number, 1-800-432-6217.

Child Abuse and Neglect, Continued

The following is a list of information that the agency receiving the report of child abuse/neglect will need:

1. Names of child and parent.
2. Age of child.
3. Sex of child.
4. Permanent address of child.
5. Present location of child (if different from above).
6. Location where incidents occurred.
7. Name and address of person or institution responsible for child's welfare.
8. Name and address of person alleged to be responsible for abuse or neglect.
9. Family composition.
10. Nature and extent of suspected abuse or neglect.
11. History of prior injuries.

The following information is optional:

1. Reporter's name, address, and telephone number.
2. Reporter's willingness to have his/her name revealed to the family.
3. Reporter's willingness to participate in assessment process.
4. A witness to incident(s) which caused the child's condition (name, address).

HEALTH SCREENING PROGRAMS

One of the functions of the school health program is to protect students' health through early identification and detection of health problems which cause disability and/or learning dysfunctions. When done in a context of individual health assessments and continuing care, a carefully planned and implemented screening program is an appropriate component of the school program.

On occasion, however, schools are requested to implement screening programs that on the surface are perceived by community and many school personnel as being valuable. In reality, however, there is frequently a lack of proper follow-up and intervention which renders the screening activity almost useless.

Therefore, when screening programs are to be considered, the following guidelines need to be carefully considered:

1. The disease or condition for which screening is done needs to be present in the age group being screened and at a significant incidence to justify the cost and/or the time spent in the screening effort.

2. The disease must have a significant effect on the quality or quantity of life and/or the learning process.

3. The disease must have an asymptomatic period during which detection and treatment significantly reduce morbidity and/or mortality.

4. Tests must be available at a reasonable cost to detect the condition in the asymptomatic period. In addition, the tests need to be utilized in the school setting with a minimum of disruption to school classes.

5. Acceptable methods of treatment must be available and accessible.

6. Treatment in the asymptomatic phase must yield a therapeutic result superior to that obtained by delaying treatment until symptoms appear.

VISION SCREENING PROTOCOLS

Vision screening is a process which allows designated persons to screen large numbers of students in a short period of time with a high probability of finding defects. Screening will not identify all students who need eye care, nor will every child who is referred require treatment. **Screening is not diagnostic.** Children who fail a screening and a follow-up rescreening must be referred to an eye specialist for a diagnostic examination.

Vision screening consists of the following tests:

1. Snellen (Allen, HOTV) which tests distance vision.
2. Stereopsis.
3. Ishihara, which tests color.
4. Cover/uncover, which tests muscle balance.
5. Plus-lens, which tests near vision.

The Vision Screening Schedule is the recommended vision screening criteria for school age children. Any of the tests on the schedule may be utilized to detect a vision problem. Sometimes the complete battery of tests will be appropriate prior to a vision referral for diagnostic testing. Please note: tests other than the ones mentioned here may be utilized. Check with your local eye specialists/providers for guidelines on tests to be used and referral criteria.

Vision Screening Schedule

Tests	Grades													Special Ed. Evaluation	New Students
	K	1	2	3	4	5	6	7	8	9	10	11	12		
Snellen	*	*	*	*	*	*	# Should be done once during remainder of school career.	#	#	#	#	#	#	*	*
Stereopsis	*	#	#	#	#	#	#	#	#	#	#	#	#	*	*
Color	This should be done once during school career.														
Cover/ Uncover	*	(Not all K's can do this test.)												*	*
Plus-Lens	#	#	#	#	#	#	#	#	#	#	#	#	#	#	#

*Screen #PRN = whenever necessary

Vision Screening Procedures

Visual Acuity

The Snellen, Allen, or HOTV type charts are the single most effective tests for visual acuity.

Screening Area

1. Area should be quiet and well lighted.
2. The chart should be placed on a light colored wall.
3. The chart should be free of glare and shadows.
4. There must be 10/20 linear feet with an unobstructed view of the chart.

Screening Supplies

1. Snellen, Allen, or HOTV chart, 10 or 20 feet.
2. Pointer (pencil, dowel) to indicate symbols.
3. Occluder (child's cupped hand, paper cup) to cover eye not being tested.
4. Yardstick to measure 10/20 feet from wall or 10/20 feet of pre-measured, non-stretchable tape (found at fabric stores).
5. List of students to be tested.
6. Pen or pencil for recording.
7. Marking tape or laminated paper "feet" to mark 10/20 foot line on the floor.

Screening Process

1. Students who wear glasses must be tested with glasses.
2. Charts should be at student's eye level.
3. Heels are placed directly on the 10/20 foot floor marker or the student may sit on a chair placed directly over the marker.
4. Student occludes the left eye first (this helps the tester remember which eye has been tested).
5. Instruct student to keep both eyes open when testing.
6. Tester points to 50 line and moves down the chart.
7. Student identifies symbols verbally or by hand signal ("E" chart).
8. If the student fails four of the six symbols on one line, move up the chart until the child can correctly identify four symbols. Success is important to the student.
9. Repeat with right eye occluded.
10. Any student failing initial screening will be rechecked by the school nurse.

Recording Findings

1. Visual acuity is recorded as a fraction. For example: 20/30. The top number (numerator) represents the 20 foot distance measured from the wall to the floor marker. The bottom number (denominator) represents the line on the chart the student is able to read.
2. A reading is recorded for each eye. Example: R20/30 L20/20.

Stereopsis

This tests the ability of the eyes to work together which allows the individual to have depth perception. Conditions detected with this test are amblyopia and strabismus.

Screening Area

1. Area should be well lighted and glare-free.
2. There must be one meter (39 inches) between the student and the tester.

Screening Supplies

1. Stereopsis Kit (Random Dot E, Titmus-Fly, etc.) which includes one pair of polarized glasses and two stereograms. Important: kit should not be kept in a hot vehicle since contents will become nonfunctional. For best results, store in a cool, dark place.
2. Ruler to measure appropriate distance for test being used. This distance may be pre-measured on a desk or table and marked with masking tape.

Screening Process

1. Check equipment each time it is used by putting glasses on and checking stereograms.
2. Students who wear glasses must be tested with glasses.
3. Place student 39 inches from tester and be sure cards will be at student's eye level.
4. Show student model "E" card and say, "This is an "E."
5. Both eyes are used together for this test. (No covering.)
6. Student puts glasses on. Tell student he/she will be able to see the E with the "magic glasses." If the glasses are too large, tape lightly with masking tape to the forehead.
7. Hold blank-sided stereograms 39 inches from the student and ask him/her to point to the card with the "E."
8. Tester shuffles cards behind back, then shows cards to student. This process is repeated until the student can identify the "E" four consecutive times.
9. If the child fails, repeat the test in two weeks.

Recording Findings

Recorded as pass (P) or fail (F).

Referral Criteria

See "Referral Criteria Chart" at the end of the vision section.

Color Vision

Screening Area

Area which is quiet, well-lighted, and free from glare.

Screening Supplies

Ishihara book with color plates or other color discrimination test.

Screening Process

1. Student is seated next to tester.
2. Refer to directions accompanying test.

Recording Findings

Recorded as pass (P) or fail (F).

Referral Criteria

See "Referral Criteria Chart" at the end of the vision section.

NOTE: Once a student passes a color discrimination test, it does not need to be repeated.

Muscle Balance

(Commonly called cover/uncover test.)

Screening Area

1. Well-lighted room.
2. Place where student and tester can sit facing each other.

Screening Supplies

1. Paper occluder or tester -- may use hand.
2. Fixation points in line with student's vision:
   a. A picture or object at 20 feet from student.
   b. A picture or object at 14 inches from student.

Screening Process

Cover Test (tests for manifest deviation)

1. Have student fixate on object at 20 feet.
2. Cover left eye with occluder or hand.
3. Observe for any movement in the uncovered right eye.
4. Cover right eye with occluder or hand.
5. Observe for any movement in the uncovered left eye.
6. Repeat procedure with fixation at 14 inches.

Alternative Cover/Uncover Test (tests for latent deviation)

1. Have student fixate on object at 20 feet.
2. Cover right eye with occluder or hand.
3. Uncover the right eye and at the same time cover the left eye. (This takes practice; tester can practice on self in front of mirror.)
4. Observe the right eye for any movement as it is being uncovered.
5. Repeat for the left eye.
6. Repeat the procedure with fixation at 14 inches.

Recording Findings

Recorded as pass (P) or fail (F).

Referral Criteria

1. See "Referral Criteria Chart" at the end of the vision section.
2. Some symptomatic problems may be double vision and/or headaches.

Near Vision - Plus Lens Test

Screening Area

See under "Visual Acuity: Screening Area."

Screening Supplies

1. Plus lenses with 2.25 diopters.
2. See under "Visual Acuity: Screening Supplies."

Screening Process

1. Students who wear glasses should be tested with glasses.
2. Place plus lenses on student (over glasses, if necessary).
3. Both eyes are used together for this test. (No covering.)
4. Ask student to identify 20/30 line symbols on the Snellen, Allen, or HOTV at 20 feet.

Recording Findings

1. Recorded as pass (P) or fail (F).
2. **Pass is when student cannot read symbols.**

Referral Criteria

See "Referral Criteria Chart" at the end of the vision section.

NOTE: Near vision cards (Rosenbaum, Sloan, Jaegar) are not recommended for use in testing children since this age group has superior powers of accommodation. Children who have problems may pass.

Vision Rescreen and Referral Criteria

NOTE: All rechecks, special education evaluations, and referrals must be done by a certified school nurse.

Check with local eye care specialists/providers for guidelines and criteria.

Test For	Results	Rescreen by Nurse	Plan	Refer
Visual Acuity	Reads 20/30 line, O.U.	PRN	Rescreen yearly	
	Fails initial screening			
	Fails to read 20/40 O.U. on rescreening		Get history/symptoms	
	Reads 20/40, 20/30 asymptomatic	PRN		
Stereopsis	Can identify symbol	PRN		
	Fails initial screening	In two weeks	Do vision muscle balance tests	
	Fails rescreen and muscle balance tests		Get vision history	A.S.A.P. (Espec. in very young children)
Color	Pass		No further testing necessary	
	Fails initial screening			
	Fails rescreen		Get family history for color deficiency. Inform student, parents, teachers. (Do not alarm parents.)	
Muscle Balance	Fails initial screening	In two weeks		
	Fails rescreen (movement of uncovered eye must be consistent and occur more than once).		Get vision history (i.e., eye surgery)	
Near Vision	Fails initial screening (Can see chart symbols with plus lenses.)			
	Fails rescreen.			

Follow-up

1. Note name of practitioner and date child is seen.
2. Check child with new glasses.
3. If Snellen results are poor with new correction, contact doctor to determine if it is the best possible correction and if special arrangements (i.e., preferential seating) is needed at school.

Eye Language

1. Right eye=O.D. (oculus dexter)
2. Left eye=O.S. (oculus sinister)
3. Each eye=O.U. (oculus uterque)
4. Both eyes=O.U. (oculi unitas)

Common Eye Disorders in Children

Eye disorders most frequently seen in children and detected in vision screening programs are described below. They are distributed as follows among preschool and school-aged children found to have vision defects.

	Preschool	School
Total With Problem	5%	25%
Refractive errors (myopia, hyperopia, astigmatism)	68%	82%
Muscle imbalance (strabismus)	15%	5%
Amblyopia	15%	10%
Other	2%	3%

Amblyopia (Lazy Eye)

Amblyopia is a condition that eye doctors are concerned about because if it is not discovered and treated before the age of six or seven, it usually leads to permanent reduction of vision in the affected eye. An eye with amblyopia has dimness of vision without any apparent disease of the eye. It is often caused when one eye turns in or out while the other sees straight (strabismus) so that a double image is sent to the brain. It may also be associated with a marked difference in the refractive error of each eye (anisometropia) resulting in two images. The brain solves this confusion by ignoring the message from one eye which gradually weakens through disuse. The usual treatment is patching the good eye in order to force the use of the weaker one. Sometimes this is combined with glasses, surgery (for strabismus), or eye exercises.

Anisometropia

Anisometropia is a condition in which there is an unequal refraction of the two eyes. Both may have myopia or hyperopia but of different degrees in each eye, or one may be myopic and the other hyperopic. Marked anisometropia is a common cause of amblyopia because the eye with the greater refractive error is ignored.

Astigmatism

Astigmatism is an eye refractive error problem in which there is blurred vision because of the irregular or defective curvature of the cornea or the lens. This results in a distorted image because light rays cannot focus on a single point of the retina. If the astigmatic person looks at a figure consisting of straight lines radiating out from a center, the lines pointing in only one direction may be seen clearly while the lines radiating out in another direction are blurred. Astigmatism affects the vision at all distances. If may be associated with myopia or hyperopia. Most cases of astigmatism can be corrected with glasses or contact lenses.

Color Deficiency

Color deficiency is an inherited vision defect, not a disease, characterized by the inability to recognize certain colors -- primarily red or green, but rarely blue or yellow. Deficiency in this visual function is not correctable; but it is important for students, parents, and teachers to be aware of any such condition. An estimated 5% of the population has defective color vision: 8% of the males and 0.5% of the females.

Hyperopia (Farsightedness)

Hyperopia is a refractive error in which the light rays focus behind the retina, either because the eyeball is too short or the lens is too thin and flat and does not bend the light rays enough. The result is that the farsighted child can see better at a distance than close-up. This condition can be corrected with glasses or contact lenses.

Myopia (Nearsightedness)

Myopia is a refractive error in which the light rays are bent and focused in front of the retina, either because the eyeball is too long or because the lens is too thick and curved so that it bends the rays too much. As a result, the myopic child can see objects at far distances. Myopia is usually first seen in children of around 6-8 years of age. It can be corrected with glasses or contact lenses.

Strabismus (Squint)

Strabismus is the term used to describe eyes that are not straight or properly aligned due to a muscle imbalance. One eye, or sometimes both, may turn in (cross eyes-esotropia) or turn out (exotropia, hypertropia). Sometimes more than one of the turns is present. The deviation may be constant or it may come and go; it may be present at birth or it may become apparent at a later age spontaneously; or it may occur after an illness or accident. Stabismus may be due to birth injuries, heredity, faulty muscle attachments, excessive farsightedness, and illness with fever. It cannot be outgrown nor will it improve by itself. An eye deviation which persists without treatment may result in permanent visual impairment because the vision in one eye is suppressed causing amblyopia. Treatment directed toward straightening the eyes can involve glasses, patches, eye drops, surgery, and eye exercises singly or in combination.

Signs and Symptoms of Vision Problems

Signs and symptoms of vision problems may be referred to the nurse for screening by the teacher, parent, or the child. Here are some signs and symptoms which the nurse may wish to share with teachers:

The student:

1. Rubs eyes frequently.
2. Attempts to brush away blur.
3. Has dizziness, headaches, nausea following close work.
4. Is inattentive during lessons from chalkboard, map, etc.

When looking at distant objects, the student:

1. Holds body tense.
2. Contorts face in attempt to see distant objects clearly.
3. Thrusts head forward.
4. Squints excessively.

When reading, the student:

1. Blinks excessively.
2. Holds book too far or too close to face.
3. Makes frequent change in distance at which book is held.
4. Is inattentive during lessons.
5. Stops working after brief periods of study.
6. Shuts or covers one eye.
7. Tilts head to one side.
8. Tends to look cross-eyed.
9. Tends to lose place on page.
10. Confuses words or letters.

Student complains of sensitivity to light (photophobia).

See appendix for self-evaluation of vision problems.

The Eye and Learning Disabilities

The problem of learning disability is a matter of major concern to educators and parents. A child's inability to read with understanding as a result of defects in processing visual symbols, a condition which has been called dyslexia, is a major obstacle to school learning and has far-reaching social and economic proliferation of diagnostic and remedial procedures, many of which may imply a relationship between visual function and learning.

A committee of ophthalmologists and pediatricians reviewed the eye and visual training in the treatment of dyslexia and associated learning disabilities and came to the following conclusions:

1. Learning disability and dyslexia, as well as other forms of school underachievement, require a multidisciplinary approach from medicine, education, and psychology in diagnosis and treatment. Eye care should never be instituted in isolation when a patient has a reading problem. Children with learning disabilities have the same incidence of ocular abnormalities, e.g., refractive errors and muscle imbalance, as children who are normal achievers and reading at grade level. These abnormalities should be corrected.
2. Since clues in word recognition are transmitted through the eyes to the brain, reading difficulties have been attributed to subtle ocular abnormalities presumed to cause faulty visual perception. Studies have shown that there is no peripheral eye defect which produces dyslexia and associated learning disabilities. Eye defects do not cause reversal of letters, words, or numbers.
3. There is no scientific evidence to support claims for improving the academic abilities of learning-disabled or dyslexic children with treatment based solely on visual training (muscle exercises, ocular pursuit, glasses) or neurologic organizational training (laterality training, balance board, perceptual training). Such training has frequently resulted in unwarranted expense and has delayed proper instruction for the child.
4. Except for correctable ocular defects, glasses have no value in the specific treatment of dyslexia or other learning problems. In fact, unnecessarily prescribed glasses may create a false sense of security that may delay needed treatment.
5. The teaching of learning-disabled and dyslexic children is a problem of educational science. No one approach is applicable to all children. A change in any variable may result in increased motivation of the child and reduced frustration. Parents should be made aware that mental level and psychological implications are contributing factors to a child's success or failure. Ophthalmologists and other medical specialists should offer their knowledge. This may consist of the identification of specific defects or simply early recognition. The precursors of learning disabilities can often be detected by three years of age. Since remediation may be more effective during the early years, it is important that the child with this problem be recognized before school age and referred to the appropriate service, if available. Medical specialists may assist in bringing the child's potential to the best level, but the actual remedial educational procedures remain the responsibility of educators.

HEARING SCREENING PROTOCOLS

(Based on recommendations of the National Committee on Audiometric Evaluation, the American Speech and Language Hearing Association, and the American School Health Association)

Hearing screening and follow-up programs are done in the schools by the school nurse in order to identify students who have learning impairments that interfere with or have the potential for interfering with the communication and educational process. Estimates of hearing loss vary, but approximately 3% to 6% of all children have a significant problem. Authorities also generally agree that early detection of medically remediable hearing loss helps to prevent related problems in speech, social, and educational development.

The identification of hearing problems is accomplished by using individual pure-tone air-conduction testing and/or acoustic immittance screening. A well-balanced program will include screening, rescreening, threshold audiometry, referrals for audiologic and medical evaluations, education and habilitation planning, and counseling for parents and teachers. Once students are identified by the program, they should be followed on a regular basis to ensure that their communication, educational, and medical needs are met.

Hearing Screening Schedule

Tests	Grades to be Screened													Spec. Ed. Eval.	New Students
	K	1	2	3	4	5	6	7	8	9	10	11	12		
Pure-Tone Audiometry	*	*	#	#	#	#	#	#	*	#	#	#	#	*	#

*Screen #PRN

Hearing Screening Procedures

Pure-Tone Air Conduction Testing

A. Equipment: Approved pure-tone audiometer calibrated to standards (American National Standards Institute (ANSI) - 1969).

B. Students to be Tested: Grades kindergarten, first, and eighth. **As a district option, third or fourth grades should be screened as time and personnel permit.** All students who are referred for testing by teachers, parents, physicians, or other school personnel must be tested. In addition, high-risk students and students who have not documented evidence of hearing tests at the designated grade levels should be tested. All students being referred for special education evaluation must be tested. All students being referred for special education evaluation must be tested according to regulation guidelines developed by the New Mexico Department of Education.

Hearing Screening Procedures, Continued

C. Testing. The two forms of testing are sweep testing and threshold testing.

1. Sweep Test. A sweep test is a screening measure whereby preselected frequencies are presented at predetermined levels and the subject is asked to give a response each time the tone is heard. The series of frequencies is presented first in the right ear and then in the left. Each child is tested individually.

2. Threshold Test. After a child has failed a sweep screening test, a threshold hearing test should be administered. The threshold test indicates the faintest level a listener can detect a tone 50 percent of a series of trials. The threshold test determines a specific degree of hearing loss as well as an acoustical "profile." A threshold audiogram serves as a basis for audiometric or medical referral.

D. Directions for Testing. The number of students in any one testing area, at any time, depends upon the size of the testing area.

Keep instructions simple. The student is instructed to raise his/her hand when he/she hears the tone. When the tone disappears, he/she is to put his/her hand down. A sample tone of supra intensity should be given to ensure that the student understands what is meant by the word "tone." Time should be allowed for the student to ask questions in the event he/she does not understand the procedure.

The audiometer should be checked by the tester before testing to make certain that it is working properly.

The student should be seated so that the tester's movement cannot be observed.

1. Sweep Test. The test procedure is now set up. Testing should include at least frequencies of 500, 1000, 2000, and 4000 Hz. These frequencies should be presented at 20 db, with the exception of 500 Hz, which can be presented at 25 db. (Pure tones are described in terms of pitch or frequency. Hertz equals units that define frequency. Loudness is measured in decibels (db).)

   a. Set (intensity) hearing level dial at 20 db (except it can be set at 25 db when presented at 500 Hz).

   b. Set audiometer on "reverse" or "tone off" so that the sound goes through the earphone only when the tester pushes the "interrupter switch."

   c. Earphones should be placed on the student by the tester to assure proper fitting so that the earphone is centered over the ear canal.

   d. A suggested order of presenting tones may be: 4000, 2000, 1000, and 500 Hz.

D. 1. e. Failure of Sweep Test. The student has failed the sweep test if he/she cannot hear one of the above frequencies in one ear.

f. The student who fails two sweep-check tests on separate days should be scheduled for a threshold test within one month.

2. Threshold Test. Since the subject has had at least two sweep tests, he/she should be familiar with the testing procedure. The threshold test indicates the lowest intensity level at which a listener can detect the tone on fifty percent of a series of trials. In a threshold test, the child will consistently state he/she "just hears" the tone. Any decision regarding a referral should be made only after the same threshold result has been obtained two out of three times for each frequency tested. Then only, should it be considered a final threshold. The threshold test is usually administered by the school nurse.

The nurse obtains thresholds for all frequencies in both ears, testing the best ear first if possible. The same frequencies are used as those used in the sweep test.

Failure of Threshold Test. The child who has failed the threshold test should be referred for follow up if he/she cannot hear one frequency in one ear at the recommended screening db level.

3. Impedance Test. Impedance audiometry (also known as tympanometry and acoustic immittance) provides information about middle ear hearing impairments. It is a valuable diagnostic tool. The use of this measure is optional in school screening programs, but cannot be substituted for the required pure-tone audiometric tests.

Calibration of Audiometer

Pure-tone audiometers are delicate electronic devices which can be easily damaged. The audiometer needs routine maintenance and accuracy checks by qualified technicians. All audiometers should be electroacoustically checked and serviced (returned to the factory if necessary) at least once a year and more often if clinical checks reveal or suggest malfunctions. Recalibration should be done annually.

Rescreen and Referral Criteria

1. Screening results and threshold tests should be properly documented. Observation of the child is most critical and mention should be made of any factors such as frequent earaches, otoscopic exam results, draining ears, excessive cerumen, mouth breathing, decreased responsiveness in the classroom, etc.

2. Initiate the referral process by discussing with the parents the observation of school personnel and the test results. Referrals should be made to appropriate resources such as the family physician, an otologist, an audiologist, or an appropriate agency depending on the child's history, family resources, and availability. A referral form such as the one at the end of the section should be used. If eligibility requirements are met, the child may be able to receive care under the New Mexico Children's Medical Services. (Refer to Children's Medical Services.)

3. When a referral is made, be sure to include the following information:

    a. A written explanation of the reason for referral.
    b. All observations, history, or other pertinent information.
    c. A copy of at least one audiogram which shows some abnormality.
    d. A request that the nurse receive a report of any findings and/or recommendations.

4. When follow-up information is received by the nurse, the information should be discussed with the parent along with any recommendations which will be shared with school personnel.

5. Guidelines for referral on hearing and tympanometer test results:

    a. First Priority. Those who fail hearing and pass tympanometer. Refer to school audiologist when student fails recheck of hearing.

    b. Second Priority. Those who fail hearing and fail typanometer. If on recheck student is over URI and passes hearing at 500, 1000, 2000, and 4000 Hz -- do not need to re-do tympanometer. If student fails tympanometer due to wax plug, refer to family doctor for prescription to manage ear wax build up. (Can go to family doctor next time they go for any family member -- usually no need to make a special trip.)

    c. Third Priority. Those who pass hearing and fail tympanometer. Recheck on tympanometer and if still has -200 or greater negative pressure, refer to physician.

    d. Other Notes.

        (1) When all else is normal, do not need to pay attention to stapedial reflex.

        (2) If low compliance is the only problem, do not need to recheck on tympanometer.

Rescreen and Referral Criteria, Continued

5. d. (3) If high compliance is the only problem, it can be a normal ear because the body resists injury well. High compliance is only significant if there is a history of head trauma. If there is a positive history for head trauma (even being "boxed in the ears") then refer to ENT specialist for possible disarticulation of the ossicular chain. (This would be a rare occurrence.)

(4) Ear Wax.

(a) If the student passes hearing and has wax plugs, just have the child see a doctor about it during the next visit for another problem.

(b) If the student fails hearing, make referral to remove ear wax plug.

AUDIOMETRIC REFERRAL FORM

Student: ______________________ School: ______________ Grade: ___

Birthdate: ______________________ District: ______________________

Parent/Guardian: ________________ Examiner: ______________________

Mother's Work Phone: ____________

Father's Work Phone: ____________

Does student or parent need an interpreter? ☐ Yes ☐ No

☐ Student receives no special education service.

☐ Student receives special education service (to include the following: speech/language therapy, occupational therapy, adaptive P.E., physical therapy, resource room, part-time or full-time special education classroom).

Parent has been notified of this referral by ☐ phone Date: __________
☐ note/mail By: __________
☐ in person

		25 db	20 db	20 db	20 db
Circle frequency missed:	Right ear:	500	1000	2000	4000
	Left ear:	500	1000	2000	4000

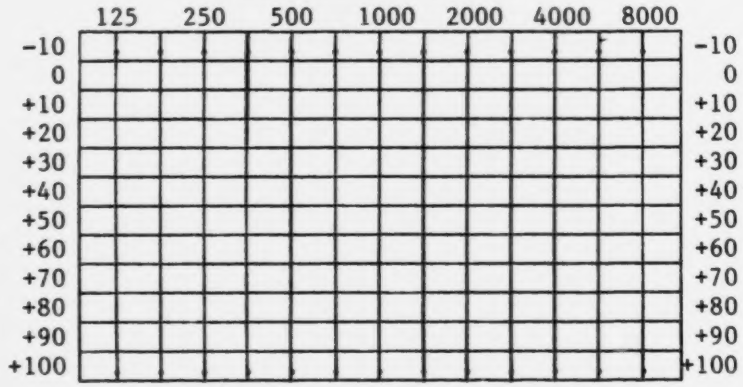
AIR CONDUCTION
Right (red) O
Left (blue) X

COLD? ☐ Yes ☐ No

ALLERGY? ☐ Yes ☐ No

HEARING AID? ☐ Yes ☐ No
☐ Left ☐ Right
Date: __________

THRESHOLD AUDIOGRAM



Otoscopic Findings: ______________________________

Hx and Remarks: ______________________________

____

Referral to: ______________________ Date: __________

Feedback and/or Recommendations: ______________________________

____

____

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The Interpretation of the Audiogram

The purpose of the New Mexico Hearing Screening Program is to protect hearing and prevent losses, thereby conserving children's hearing. Permanent damage can be prevented by finding children with slight audiometric losses and seeing that these children receive otologic care. Thus hearing is restored to normal, and minor problems are prevented from developing into major ones. In addition, children who already have extensive losses are located and receive otologic care.

Audiometric testing includes:

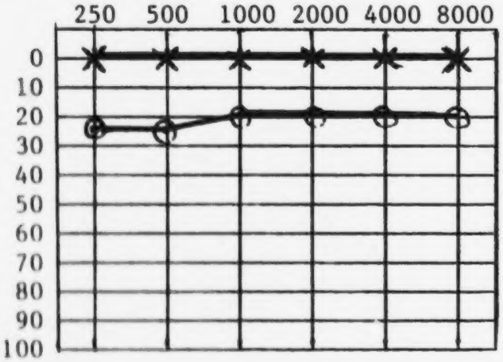
A. Sweep testing, the screening of grades K, 1, and 8, as well as the screening of any child suspected of a hearing problem and high risk children.

B. Threshold testing of those children who fail the sweep test (threshold results recorded on audiogram).

When to Refer to Otologist or Audiologist

Refer to otologist or audiologist if child cannot hear at least one frequency in one ear at the 20 decibel level (or 25 db for the 500 Hz frequency).

Example of a Failed Test



Child misses 2 tones at 20 db level.

Slight loss but medically significant.

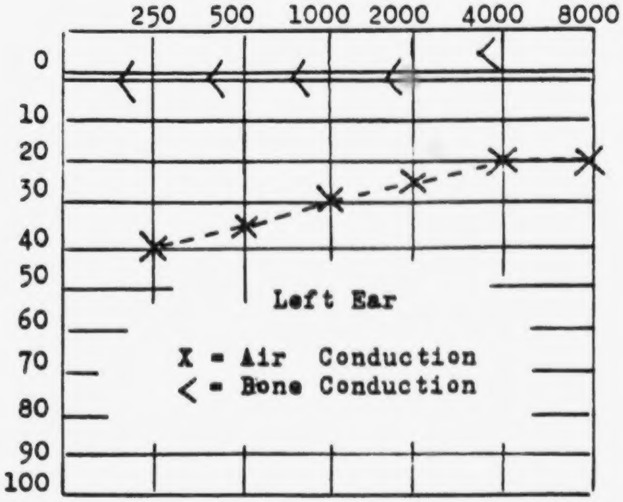
Note "peak" at 2000 frequency. Audiometric pattern of best hearing at 250 Hz often associated with conductive (medically reversible) hearing loss.

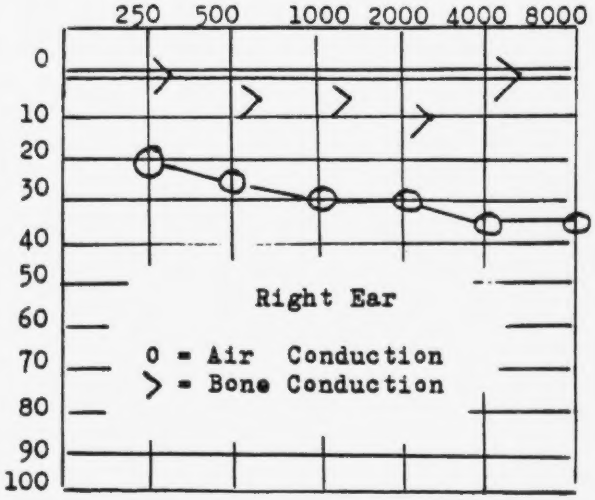
The Interpretation of the Audiogram, Continued

Types of Hearing Losses

There are three general types of hearing losses: conductive, sensorineural, and mixed.

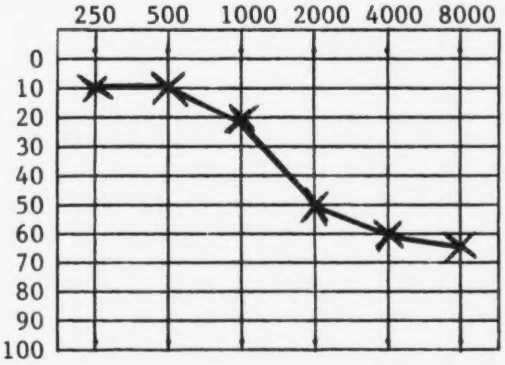
A. Conductive losses are the result of pathology in the outer or middle ear. On the audiogram there is usually a gap between bone testing results (in brackets) and the air results (indicated by "X" or "O").





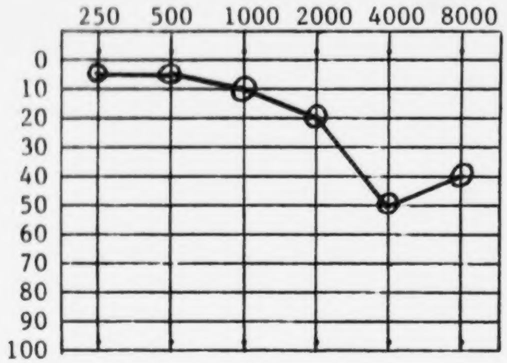
B. Sensorineural (nerve or perceptive) losses are the result of inner ear and auditory nerve pathologies. Common patterns of sensorineural losses are shown below.

Classic Pattern Nerve Loss



Good hearing in low tones. Sharp loss in high tones. Refer to otologist. Loss usually not amenable to medical care. Often helped by hearing aid. Seat near front of classroom. Child will have trouble hearing these sounds: S, SH, TH, CH, F, V, J. Child often gives the impression of hearing but misses parts of words and has trouble hearing distinctly.

Acoustic Trauma (Nerve Loss)



Dip in approximately 4000 Hz area. Loss caused by repeated exposure to excessively loud sounds, such as from guns, heavy equipment, or amplified musical instruments. Loss will become progressive if person remains in noisy environment. Loss not amenable to medical care. Remove individual from noisy environment. Keep under observation of otologist. If dip is extensive, child may need special seating because he/she does not hear these sounds in speech: S, SH, TH, CH, F, V, J.

Ability to Hear Speech

If you know how well and individual can hear the frequencies, you will be able to have some idea of how well he/she can hear speech. The overall speech range is 250-4000 Hz. In the spoken word vowels are composed of frequencies from primarily 250 to 1000/1500 Hz. Consonants are composed of frequencies from primarily 1000/1500 to 4000 Hz (in addition to a few higher and lower frequencies). For example, if the student's audiogram shows good hearing in the low tones but not in the high tones, he/she will hear the vowels but miss consonants in words; thus "so" will sound to him/her like "oh."

The Audiological Assessment

Speech Hearing Testing. If you receive an evaluation report on a student who has been tested by the audiologist at an audiological center, you will have more accurate information on the individual's hearing for speech. Under controlled conditions, the student is tested on his/her ability to hear spoken words which he/she repeats to the audiologist. Evaluation reports contain results listed as:

1. Speech Reception Threshold (SRT) which is stated in terms of decibels. It indicates the level of intensity (loudness) required to be able to hear and repeat correctly a certain quantity of specified words.

2. Discrimination Score (Articulation Score) stated in terms of percentage. It is the percentage of certain words heard correctly when speech is made louder. It is of special value in the selection of hearing aids. It can be helpful for the school nurse in roughly estimating how clearly and distinctly speech is heard by the student when he/she is wearing a hearing aid which amplifies sound.

Hearing Conservation

A school program should include (as a component of Health Education) classroom activities and information for students which emphasize ways of preventing hearing loss. More than 20 million Americans are exposed to hazardous noise on and off the job. A hearing conservation program should be designed to help students learn how to protect their hearing at work, home, and play.

Programs should include:

1. Normal hearing: the anatomy and physiology of the ear and sensorineural hearing system.

2. Sound and the measurement of hearing function.

3. Hearing loss types and the effects they have on one's functioning in the world.

4. How hearing ability is lost; for example, through infections, some medications, and from trauma such as head injuries or noise.

5. Noise pollution in modern society and how it can affect hearing.

6. Prevention measures that can be taken, as well as self responsibility to take those measures. (Avoidance of loud noises and music -- especially use of earphones; use of ear plugs or muffs; following rules such as not putting anything into the ear canal; keeping ears dry; seeking medical attention for ringing in the ears, ear pain or discomfort, dizziness, hearing loss, or frequent headaches.)

Signs and Symptoms of Hearing Problems

The classroom teacher plays an important role in recognizing and reporting children who show symptoms of possible hearing loss. The child who presents the following may experience difficulty in hearing and should be referred to the school nurse for further investigation:

Physical Conditions

Draining ears.
Ears filled with dried wax or crust from draining ears.
Inflammation of the ear or area around it.
Mouth breathing.
Upper respiratory allergies.

Health History

Chronic colds.
Ear infection.
Mastoiditis and meningitis.
(Also keep alert for any evidence of hearing loss after mumps, measles, chicken pox, scarlet fever, typhoid, diptheria, and after any acute head cold accompanied by a high fever.)

Complaints

Pain in ear or around ears.
Ears stopped up.
Ringing or buzzing in ears.

Behavior

Doesn't pay attention.
(Some children may develop a habit of inattention even when hearing is normal, but the presence of inattention should not be dismissed on such a possibility. The child should be given an audiometric checkup to be sure.)
Asks to have things repeated.
Turns head to have things repeated.
Turns head to one side when listening.
Leans forward when listening.
Stares intently at speaker.
Appears confused or bewildered when listening to speaker.
Hears better when directly in front of speaker.
Interrupts conversation and is not aware that others are talking.
Has trouble with oral directions.
Does better written work than oral work.
Has poor speech.
Withdraws from group activities in which hearing is necessary.
Progresses slowly in school.
(The child with partial hearing may be mistaken for being dull, careless, or stupid.)

Suggestions for the Classroom Teacher of the Hearing-Impaired Child

Since it is essential that the teacher understands the child's hearing problem, the following is presented to describe briefly some of the listening problems encountered by the hearing-handicapped child and to provide helpful suggestions for the teacher. It is important to remember that the teacher can establish a feeling of acceptance of the hearing-impaired child and his/her patience and consideration can provide a pattern for members of the class. It is also important that the teacher be alert for signs of improvement or additional hearing loss and he/she should discuss these observations with the school nurse.

Significance of Loss

How much difficulty the child experiences will depend upon the amount and type of his/her hearing loss. If the child has trouble hearing speech sounds, it will make it difficult for him/her to follow directions. Very probably he/she will make mistakes in spelling and will have trouble producing correctly some of the speech sounds.

When the child has trouble hearing all the tones, it is to be expected that he/she will experience difficulty listening. However, if the child has a hearing loss in only the high tones, he/she may hear some of the sounds very well and others very poorly. This may be confusing to the teacher because it appears that the child hears. Although he/she seems to "hear" it may be that he/she does not know what was said, since he/she fails to hear the consonants which are the key sounds for the meaning of words. Very often the child with a high tone loss fails to hear the following speech sounds:

SH - CH - TH - S - F - V -J

The Child Who Has "One Good Ear"

This child can hear speech with his/her "good ear," but if he/she cannot see the speaker, he/she does not know from where the sound is coming. On the playground, for example, he/she may not know which child in back of him/her is calling because he/she cannot determine the location of sound. (The child who rides a bicycle should be especially alert in traffic because he/she will not be able to know from where -- in back of him/her -- the sound is coming.

The child will have trouble listening in the presence of noise.

The child will experience difficulty listening when a number of people are talking.

The Child Who Wears an Aid

This child also is disturbed by environmental noises and has difficulty following conversation in a group.

Suggested Seating Directions

Loss in Both Ears

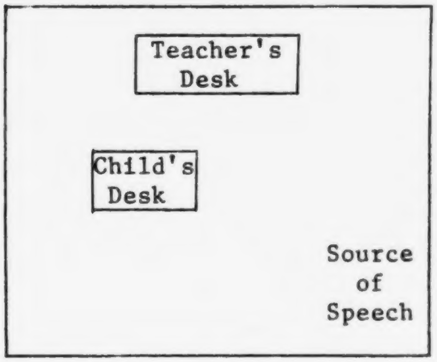
Seat the child who has a loss in both ears directly in front of the teacher.

Loss in One Ear

If the child has a loss in only one ear, seat him/her at the front of the room and to one side so that his/her better ear is toward the source of the speech and recitations of classmates. The following seating diagrams enable the child to hear most of the speech of classmates, as well as that of the teacher.

Example A

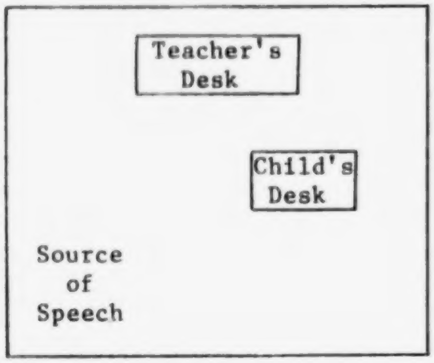
Child has good right ear
and poor left ear.



The child's seat is in front
and slightly to the left.

Example B

Child has good left ear
and poor right ear.



The child's seat is in front
and slightly to the right.

Assisting the Hearing-Impaired Child in Speaking Situations

Observe the following when speaking to the child:

1. Do not stand with your back to the window.

   It is difficult for the child to read the teacher's lips if he/she must face the light or venetian blinds.

Suggestions for the Classroom Teacher of the Hearing-Impaired Child, Cont.

2. Be sure that the light is on your face.

3. Face the child.

    The child will have difficulty in lip reading if you are walking or if you are at the other side of the room.

4. Do not stand too close to the child.

    If you are standing almost above a child's desk, the child will be forced to tilt his/her head back to read your lips.

5. When writing on the blackboard, do not stand with your back to the class when you provide explanations.

6. Speak slowly and distinctly.

7. Speak naturally. Do not exaggerate lip movements.

8. Do not talk too loudly.

    This is especially important for the listener who wears a hearing aid.

9. If the child does not understand you, restate and rephrase what you have just said.

    Very often repeating what has been said does not actually help the child to follow the conversation. Restatement of the idea is much more effective.

Assisting the Hearing-Impaired Child in Learning Situations

1. Acquaint the child with the vocabulary when a new topic is introduced.

    Place important words on the blackboard and first discuss their meaning. This procedure will serve as an aid to the other members of the class as well as to the hearing-impaired child.

2. Present new words to the child before conducting the reading group sessions.

    If the child is in a reading group, he/she will need extra help. New words should be presented to him/her individually prior to the group lesson so that he/she will be able to know and recognize them at the time of the session. During group reading, he/she should sit directly in front of the teacher.

Giving Directions to the Hearing-Impaired Child

1. Have the child's attention before you give directions.

   Some means must be established so that the hearing-impaired child knows when attention must be directed to the teacher. You may wish to give a tap on the desk so that he/she will look up. It is inadvisable to touch the child to attract attention. Often, if you say the student's name first, he/she will respond immediately. Avoid doing it in such a way that the student feels conspicuous.

2. Be sure that the child has understood the directions.

   Encourage the child to feel that it is acceptable to say, "I didn't hear," and to request that directions be repeated or restated.

   Give the child an opportunity to repeat the directions. This will prevent him/her from feeling unsure of himself/herself and reduces possible errors.

3. Place directions on the blackboard when the child has difficulty in understanding.

Understanding the Hearing-Impaired Child's Problem

Fatigue

Do not overestimate the child's ability to hear as he/she may hear very well at close range and follow you attentively, but the strain of lip reading is very tiring and it will be hard for him/her to maintain attention for long periods of time. Give the child opportunities to relax and rest his/her eyes.

Language Development

If the child's level of learning is lower than that of his/her classmates, it may be due to lack of experience in acquired language instead of limited I.Q. Most children with hearing difficulties are appreciably retarded in language development. Many words and ideas have no meaning because hearing-handicapped children have been unable to hear the words. Every effort should be made to compensate for this loss by encouraging the child to do extra reading, take an active interest in spelling, original writing, etc. Remember that the normal-hearing child is able to "pick up" much language which the hearing-impaired child is unable to acquire. Therefore, classroom activities and study under the teacher's supervision is vitally important for the hearing-handicapped child.

The New Mexico School for the Deaf

The school is located at 1060 Cerrillos Road, Santa Fe, New Mexico 87501. It is a state-supported, residential, educational institution for the care and education of the deaf and hard-of-hearing children between 5 and 21 years of age who cannot function successfully in a public school setting.

Anyone from birth to 21 years of age suspected of any kind of a hearing problem is eligible for an audiological evaluation. Free diagnostic services are provided for educational placement in speech, language, and psychological assessment.

SCOLIOSIS SCREENING PROTOCOL

The goal of a school scoliosis screening program is to identify spinal curvatures early enough so that they can be treated without need for surgery.

1. Screening Scoliosis

Students are screened for scoliosis by visual inspection. Tops/shirts must be removed. Girls can wear bras, bathing suit tops, or halter tops.

Visual inspection is utilized so as to pick up any asymmetry in a standing and bending position. (The forward bending test.)

2. Grades to be Screened

a. All 8th or 9th grade students.

b. 5th, 6th, and 7th grade optional.

Scoliosis Screening Schedule

	Grades To Be Screened													Special Ed. Evaluation	New Students
	K	1	2	3	4	5	6	7	8	9	10	11	12		
Mass Screening Programs	#					#	#	#	* or	*				#	#

*Screen #Optional

3. Signs and Symptoms

a. Scapular prominence or unequal scapula.

b. Unlevel shoulders.

c. Unlevel hips.

d. Irregular gait.

e. Unequal leg length.

f. Cafe-au-lait spots (usually associated with Von Recklinhausen's Disease).

g. Curve in spinous process alignment.

h. Rib hump/asymmetry on forward bend.

Introduction to Scoliosis

Scoliosis, characterized by lateral curvature and vertebral rotation, is often associated with kyphosis (hunchback) and lordosis (swayback). The following classification from Ciba's Clinical Symposia on Scoliosis, will help the school nurse relate to terms used frequently in reports from the orthopedists.

Nonstructural Scoliosis

Includes postural scoliosis and compensatory scoliosis. Compensatory scoliosis usually results from a leg length discrepancy with the pelvis dipping down on the short side. (Many of these need medical evaluation.)

Transient Structural Scoliosis

Includes sciatic scoliosis, hysterical scoliosis, and inflammatory scoliosis (seen with perinephric abscess or similar infection).

Structural Scoliosis

Approximately 140 out of every 100,000 Americans have scoliosis. Thirty percent of these are secondary to another disorder and the remaining seventy percent are idiopathic. Idiopathic scoliosis can be of three types: infantile, juvenile, and adolescent. The most common type and the one that needs to be identified in school screening programs is adolescent idiopathic scoliosis.

1. Idiopathic, also called genetic scoliosis because 90% of these probably are genetic. Both terms are used synonymously for scoliosis of unknown etiology.

   Adolescent idiopathic scoliosis is not usually seen until age ten, and it is four to eight times more common in girls than boys. The onset is during the growth spurt of the early teens with an incidence that has been estimated at 10%. However, only two percent of the total population has a significant curve that will require bracing or surgical correction.

2. Congenital Scoliosis, probably not genetic but due to vertebral or extra-vertebral defects. (Need early treatment, but school screening is sometimes first to pick these up.)

3. Neuromuscular Scoliosis, includes forms related to poliomyelitis, cerebral palsy, muscular dystrophy, Friedreich's ataxia, myelodysplasia, parapletia, etc.

4. Neurofibromatosis (Von Recklinhausen's Disease).

5. Mesenchymal Disorders

   a. Congenital, includes Marfan's Syndrome, etc.
   b. Acquired, e.g. rheumatoid arthritis, Still's Disease.
   c. Others, e.g., Scheuermann's kyphosis (often picked up on school screening) and osteogenesis imperfecta.

Introduction to Scoliosis, Continued

6. Trauma

    a. Vertebral, such as fracture, irradiation, surgery.
    b. Extravertebral, such as burns and thoracic surgery.

The primary focus of school screening is the idiopathic, or genetic, scoliosis which accounts for 80% of all scoliosis. The majority of idiopathic cases are problems of the pre-teen and teenage child. Priority screening includes ages 10 through 16, boys as well as girls, and should be done once during these years. Some children need more frequent observation, but staffing does not always permit this. It is classified by age of onset:

1. Infantile, before 3 years of age.

2. Juvenile, age 3 to onset of puberty, usually age 10. Sexes evenly affected. Most are right thoracic. (When the scoliosis check is included in health appraisals of elementary school children, a surprising number of early curves are detected.)

3. Adolescent, age 10 to skeletal maturity; 6 out of 7 cases are girls; right thoracic and double major curve patterns predominate. It may or may not progress. Dr. Hugo Keim, author of Ciba's symposia on scoliosis, says research supports the theory of genetic programming. "The genetic message will progress to a predetermined severity unless the course is interrupted by proper medical treatment, usually bracing with exercises, or surgery, or a combination of both, BUT NEVER BY EXERCISE ALONE." (Kypohotic and lordoctic curves do respond to exercise alone, in many cases. Such a program should be supervised closely by a physician trained in the treatment of spinal deformity.)

4. Equipment for Testing (Optional)

    a. Lined grid for background reference.
    b. Paper footprints.
    c. Tape measure.
    d. Plumb line.
    e. Scoliometer (check with local orthopedic care providers).

5. Environmental Conditions Conducive to Testing

    Student education is important for the success of the screening process. This is best done in a classroom setting prior to the screening date. Students should understand what curvature of the spine means, the different kinds of curves, the importance of early detection, what screening can and cannot detect, and what to expect if they are referred to a physician.

    Screening will also go smoother if screening personnel are introduced or at least identified. The screening procedure must be described to the students.

    The area for screening should be well lighted and permit screening individually with privacy. Boys and girls should be screened separately and individually to ensure further privacy.

6. Directions for Screening

a. Step 1. Student stands with back to screener. Student stands erect, with feet together, knees straight, arms relaxed at the sides, and weight evenly distributed on both feet with shoes.

   Screener checks the following:

   1) Elevated shoulder, scapula.
   2) Curve in spinous process alignment.
   3) Asymmetric distance between arm and trunk (compare two sides).
   4) Level of iliac crests (compare two sides for unevenness).
   5) Use plumb line to check if spine is straight. Hold string on vertebral prominence at base of neck. Let weighted end fall free. Check to see if spine deviates outside plumb line. (Optional)

b. Step 2. While in standing position, the screener also checks the individual from the side looking for Kyphosis (roundback) or Lordosis (swayback).

c. Step 3. Next, the student will be directed to bend forward at a 90 degree angle, keeping the knees straight, feet together, arms hanging with palms together and head down. The screener should examine the student in this position from both the front and back view, noting:

   1) Asymmetry of the thoracic and lumbar areas.
   2) Rib hump present in upper or lower back (scoliometer may be used to measure the degree of deviation).
   3) Curve in the spinous process alignment.

d. Step 4. With the student remaining in this forward bending position, check the student from the side looking for an accentuated spinal hump (Kyphosis).

7. Criteria for Referral

a. Rib hump noted on recheck.
b. Other discrepancies noted.
c. If using scoliometer, check with local orthopedic care provider to provide referral criteria.

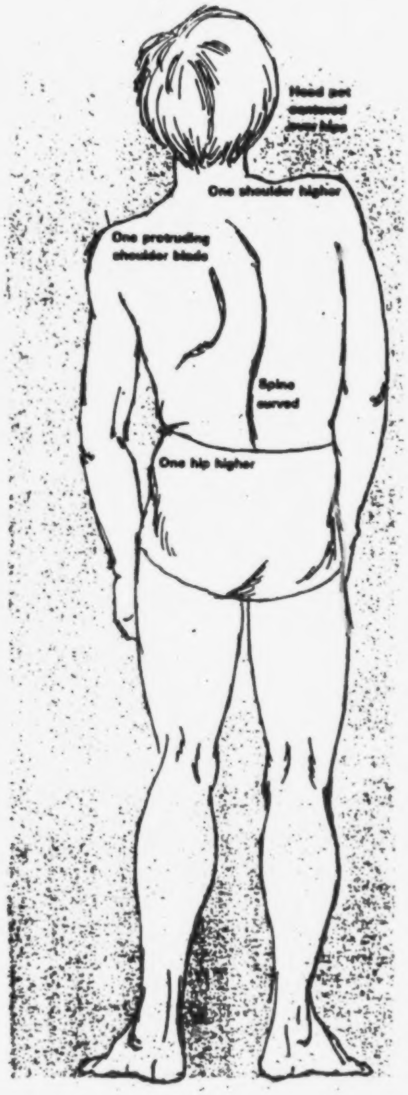
Scoliosis Screening Procedure

Step One

The student will be directed to stand erect, facing the examiner with feet slightly apart, knees straight, arms relaxed at the sides, and weight evenly distributed on both feet.

Students should be encouraged to avoid slouching or standing "at attention." The screener should check the individual from the front and back, noting:

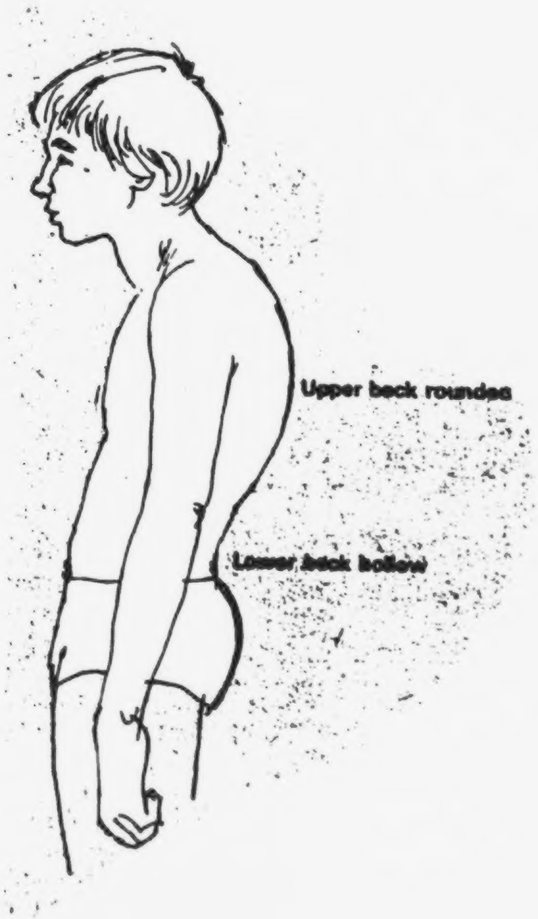
1. Elevated shoulder or scapula.
2. Curve in spinous process.
3. Increased distance between arm and trunk.
4. Asymmetry in levels of hips (Iliac Crest).


Head not centered over hips
One shoulder higher
One protruding shoulder blade
Spine curved
One hip higher

Scoliosis Screening Procedure, Continued

Step Two

While in the standing position, the screener also checks the individual from the side, looking for accentuated roundback (Kyphosis).

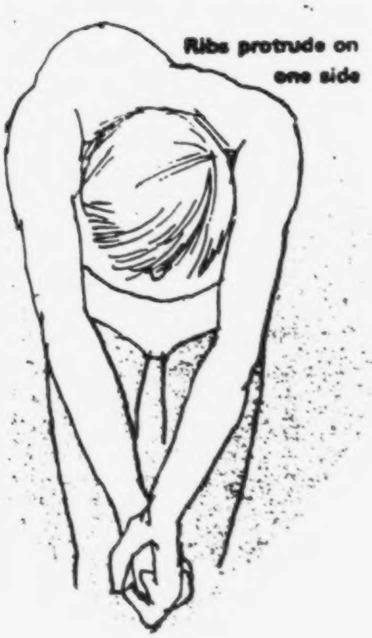

Upper back rounded
Lower back hollow

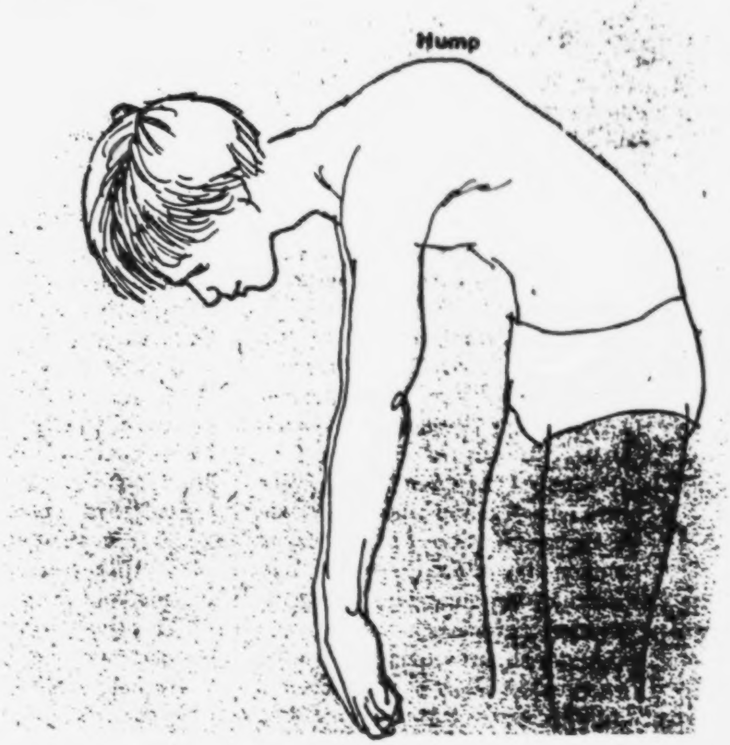
Scoliosis Screening Procedure, Continued

Step Three

Next, the student will be directed to bend forward at the waist 90° (toward the screener), keeping the knees straight, feet together, arms hanging with palms together and head down. The screener should examine the student in this position from both the front and back view, noting:

1. Asymmetry (uneven contours) of the rib cage or upper back.
2. Rib hump present in the upper or lower back.
3. Curve in spinous process alignment.





Resources available for further diagnosis and screening.

A. Family physician/orthopedic physician.

B. Carrie Tingley Hospital, 1128 University NE, Albuquerque, NM 87102. This is also a good resource for consultation, films, and in-service training.

Scoliosis Screening Letter to Parents

Dear Parents:

On ________ (date) ________, your school nurse will conduct a screening program to find children with posture deviations, including scoliosis (curvature of the spine). If scoliosis is detected early and appropriately treated, progressive spine deformity can be prevented.

The procedure for screening is simple: the nurse looks at the student's back, standing and bent forward, and also looks at the way the student walks. Boys and girls will be screened in separate settings. Girls will be asked to wear a halter underneath clothing and boys will be screened with shirts removed to enable the nurse to view the entire spine.

If your child has a possible curvature or other significant posture problems, you will be notified and asked to take the child to your family physician for further examination. If you do not have a family physician, contact the school nurse for assistance in obtaining a medical evaluation for your child.

Sincerely yours,

________________________ ________________________
Principal School

________________________ ________________________
School Nurse Phone Number

Scoliosis Information for Students

Scoliosis is a side-to-side curve of the spine or backbone. Normally, the spine is straight, but in some people it does begin to curve, and the curve can get worse as you grow.

More girls have scoliosis than boys, but boys can have it, so it is important for everyone to have their backs checked. Your school nurse will be checking your back for a curve. If the nurse finds one, you and your parents will be told so that your parents can take you to the doctor.

The doctor will examine your back, and if the doctor thinks it is necessary, you will be asked to get an x-ray of your back. None of this is painful, and it is very important to follow your doctor's instructions so that the curve will not get worse.

There is no medicine that will cure scoliosis, and exercise alone will not make the curve any smaller. If the curve is getting bigger, the doctor may want you to wear a brace and do some exercises to help make it smaller.

Scoliosis is not contagious like a cold or the measles. You cannot catch it from anyone else.

SCOLIOSIS REFERRAL FORM

School: ________________________________ Phone Number: ____________

Date: ________________________________

Dear Parents:

I have screened ____________________ to detect possible postural defects. Attached is a copy of the screening results. Although the results do not definitely mean there is a problem or that treatment is needed, we request that you have your family doctor, osteopath, pediatrician, or orthopedist examine your child. Please ask the examining doctor to complete this form when the examination is completed, and return the form to me.

Thank you for your cooperation. If there are any questions, please feel free to call me.

____
School Nurse

* *

PHYSICIAN'S FINDINGS AND RECOMMENDATIONS

We request that you evaluate this student for the presence of scoliosis or other postural defects. Please see the attached Postural Assessment Form which shows the results of our postural screening at school.

☐ No significant findings at this time.
☐ Need for further evaluation.
☐ Reexamination or treatment recommended.

Additional Comments: ____
____
____
____

Date of Present Exam ______________ Date of Next Exam ______________

Physician's Signature: ____________________________
Name (Print): ____________________________
Phone Number: ____________________________

SCOLIOSIS PROGRAM EVALUATION FORM

Recording Sheet for Spinal Screening for School Year ____ to ____

for ______________________________.
District

Date of Screening: ______________________________

Person Screening: ______________________________

Title: ______________________________

School: ______________________________

SCREENING RESULTS	GRADE 5	GRADE 6	GRADE 7	GRADE 8
1. Normal (no referable findings)				
2. New abnormal (new referable findings)				
3. Old referable findings not under care				
4. Old referable findings under care				
5. Total number screened (add figures from items 1-4)				

FOLLOW-UP RESULTS	GRADE 5	GRADE 6	GRADE 7	GRADE 8
6. Total number for follow-up (add figures from items 2 and 3)				
7. Follow-up results reported				
a. Diagnosed (under care)				
b. Not diagnosed				

Remarks:

PEDIATRIC HYPERTENSION SCREENING PROTOCOL

Introduction & Purpose

In accordance with the recommendations of the American Academy of Pediatrics Task Force on Blood Pressure Control in Children, the following screening procedure is recommended to detect hypertension in children.

The routine screening procedures may be performed annually on all children three years and older enrolled in well-child clinics and on those children whose parents request the screening.

Equipment

1. Quiet environment.

2. Table or desk and chairs so child can sit comfortably with right forearm supported at heart level.

3. The appropriate size cuff for the child.

4. Manometer.

5. Stethoscope.

Hypertension Screening Procedure

1. Familiarize the child with the blood pressure unit.

2. Have the child comfortably seated at the table or the desk so that his/her right arm is slightly flexed and the entire forearm is supported at the heart level. (Be sure the child has voided since a full bladder can elevate blood pressure.)

3. Use the appropriate size cuff (two-thirds of the length of the upper arm must be covered and the bladder of the cuff should be long enough to encircle the arm comfortably).

    a. Children age 3-5 years usually take a 5 cm. wide cuff.
    b. Children 5-10 years or more usually take a 9 cm. wide cuff.
    c. Children 10 years or more usually take an adult size cuff.

    It is important that a child's body structure and size be taken into account before cuff selection is made.

4. Wrap the collapsed cuff snugly and smoothly around the bare arm so the distal margin of the cuff is at least 3 cm. above the elbow.

5. Rest the arm on the desk or the table and palpate for the exact location of the brachial arterial pulse.

6. Inflate the cuff to a pressure about 30 mm. of mercury above where the palpable pulse disappears.

7. Open the valve slightly so the pressure drops gradually. From this point, observation is made by auscultation. The vibrations from the artery under pressure are utilized as indicators of the blood pressure reading. (If the release of pressure is too rapid, the blood pressure level will be falsely low.)

8. Simultaneously to opening the valve, press the bell of the stethoscope firmly over the brachial artery and note the pressure reading at which the pulse sounds first become audible; this reading is taken as the systolic pressure.

9. As deflation proceeds, the sounds become louder, then become muffled, then disappear. Continue listening to zero pressure to detect the presence of an occasional blank range known as an ausculatory gap.

10. Record the readings where the first value (systolic pressure) is first heard and the second value (diastolic pressure) become muffled.

11. If an immediate repeat reading is necessary, fully deflate the cuff.

Some confusion still exists owing to the lack of uniformity with which physicians and nurses accept phase IV (muffling of the Korotkoff sounds) and phase V (the disappearance of the Korotkoff sounds) as the diastolic criterion. The American Academy of Pediatrics Task Force on Blood Pressure Control in Children recommends phase IV (muffling) as the measure of diastolic pressure in infants and children. The New Mexico Hypertension Advisory Council advises the use of "muffling" as the diastolic pressure to be recorded for our screening and referral purposes. They feel that the use of phase V (disappearance of sounds) is subject to more influence by the condition of the instrument being used. (Reference: Liberman, Ellen, M.D., "Children with Hypertension," American Family Physician, 12:4, October 1975.)

You may want to record phase I (systolic), phase IV (muffling) and phase V (disappearance), i.e., 120/80/40. However, this is not necessary.

Follow-Up of Elevated Blood Pressure

1. Children found to have blood pressure levels above the following values for age should have two more blood pressure checks on separate occasions or use the Bogalusa Chart.

Age	Sex	Systolic mm Hg.	Diastolic mm Hg.
3- 5 years	M/F	120	70
6- 7 years	M/F	125	80
8-10 years	M/F	130	80
11-13 years	M/F	140	80
13-14 years	F	140	85
13-14 years	M	140	80

The percentile graphs developed by the Task Force on Blood Pressure Control in Children are also acceptable to use when monitoring blood pressure in children. Since blood pressure does not normally follow the same percentile curve, all referrals are made on the basis of three blood pressure checks on separate occasions. If the percentile graphs are used, the child will be referred if the three blood pressure checks are above the 95th percentile for age. These values correspond very closely to those developed by Lieberman.

2. When a child is found to have an elevated blood pressure, inquire as to whether he/she may have been going through a period of illness or stress. If so, arrange the next blood pressure check to be performed when the period of illness or stress is over. (School examination periods for adolescents; or child coming in with fever.)

3. If after three blood pressure checks are performed on separate occasions and the child is found to be hypertensive, obtain the following history:

    a. If the patient is taking any drugs known to elevate the blood pressure, i.e., steroids, oral contraceptives, etc.

    b. If the patient has a history of conditions known to cause hypertension, i.e., renal disease, obesity, smoking.

    c. Familial occurrence of hypertension or coronary artery disease.

Hypertension Referral

1. A child should be referred for further evaluation if found to have an elevated blood pressure for his/her age on three separate occasions.

2. The child should be referred to his/her family physician or to a physician in the area who has agreed to see patients from screening clinics.

Hypertension Referral, Continued

3. Within a month from the time of the blood pressure check, the school nurse should contact the child's family to see what follow-up has occurred; and make further follow-up plans on the basis of the information received.

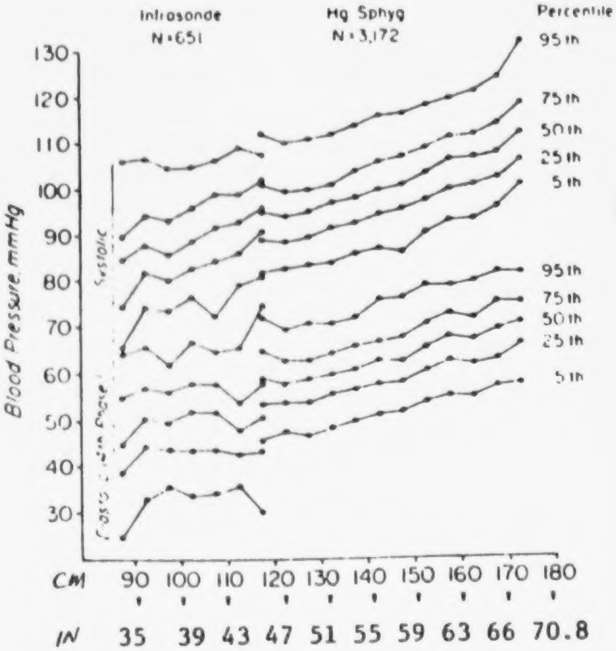


Figure 1. Selected percentiles of blood pressure as measured by Infrasonde and mercury sphygmomanometer by height, in children 2½ to 14 years of age. The Bogalusa Heart Study, 1973-1974. (From Voors: A.W., Webber, L.S., and Berenson, G.S.: A consideration of essential hypertension in children. Practical Cardiology, 3:29, May 1977, with permission.)

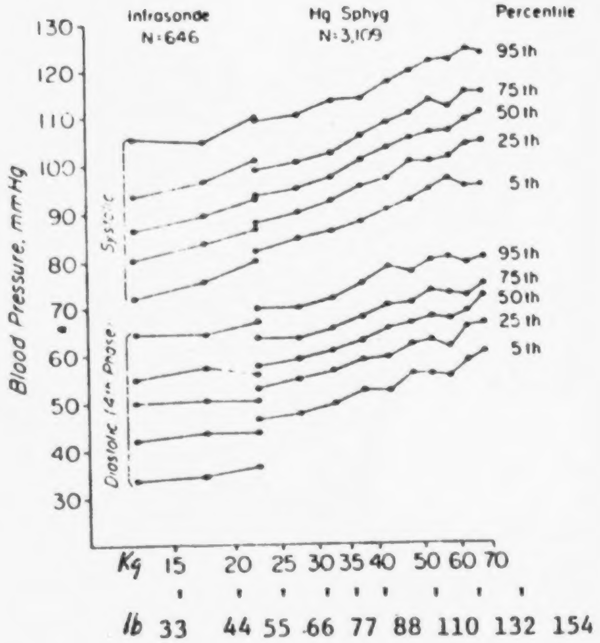


Figure 2. Selected percentiles of blood pressure as measured by Infrasonde and mercury sphygmomanometer by weight, in children 2 to 14 years of age. (The Bogalusa Heart Study, and Berenson, G.S.: A consideration of essential hypertension in children. Practical Cardiology, 3:29, May 1977, with permission.)

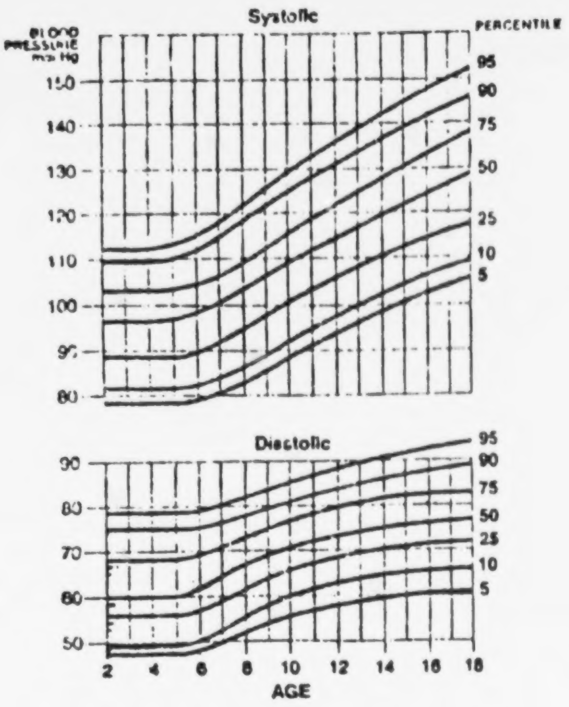


Figure 3. Percentiles of blood pressure measurement in boys (right arm, seated).

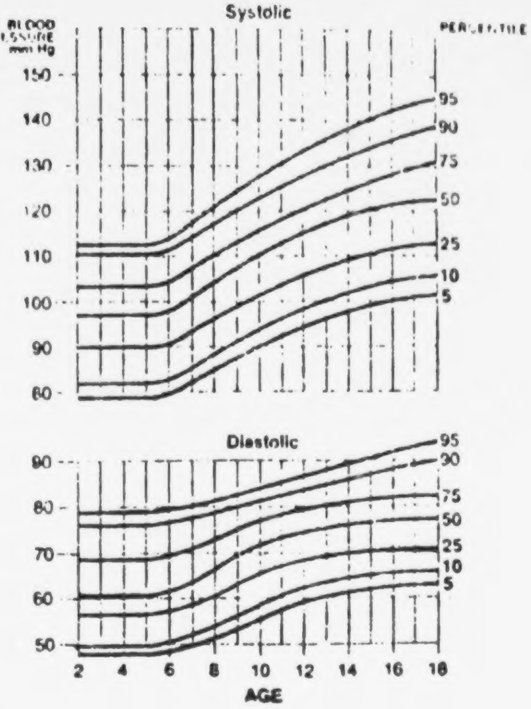


Figure 4. Percentiles of blood pressure measurement in girls (right arm, seated).

Blood pressure values, unlike height and weight in children, will not precisely follow percentile tracks. There is considerable variation in most children's pressures. These charts provide a mechanism for a child's pressure to be recorded so that a pattern over a period of time may be observed.

Blood pressure measurements, like those of weight and height, should be obtained and plotted at least once yearly. Because a single elevated measurement (i.e., greater than the 95th percentile) in an apparently healthy child does not necessarily reflect disease, it is necessary to repeat these measurements over time to obtain a trend.

Reference: Pediatrics - "Report of the Task Force on Blood Pressure Control in Children." May, 1977.

Fixler and Laird, "Validity of Mass Blood Pressure Screening in Children," Pediatrics, Volume 72, No. 4, October, 1983.

SPECIAL EDUCATION

Every school is likely to have, among its population, 3-5% special education students; i.e., children with physical, mental, or emotional problems that interfere with normal growth or development. A school health program is incomplete if provision is not made for the identification of these children and for the adaptation of the regular school program to meet their needs. Unless this is done, the physical and mental health of the exceptional child may be further impaired, and the child will not be able to take full advantage of educational opportunities provided by the school.

This means of identifying these children are related to the degree of exceptionality. Some conditions are obvious; some are detected by the teacher; others become apparent as a result of screening tests and medical, dental, and psychological examinations. Still others are reported by the parents or the child's physician or dentist. The school should encourage parents to seek adequate and complete treatment for children so that all remedial handicaps may be corrected or improved. Children having non-remediable exceptions should be helped to compensate for their problems. Students placed in special education programs may receive services until 21 years of age or until completion of a planned course of study. When rehabilitation services for students ages 16 or over are needed, the Division of Vocational Rehabilitation may also be contacted. Their services are many and are available throughout the state.

Since social adjustment is very important to these children, the child should be treated, as far as possible, just as any other child. Modifications in the regular school program should, if possible, be made to enable him/her to remain with his/her regular class. Assignment to special classes or schools should be kept to a minimum and all pupils in such classes should join with regular classes wherever feasible; e.g., in assembly, in music, etc. The health condition of exceptional children should be periodically evaluated to assure no further modifications are necessary.

According to the 1984 Standards for Special Education:

2.8 EDUCATIONAL APPRAISAL AND REVIEW COMMITTEE is defined as:

> The Educational Appraisal and Review Committee is a group of persons responsible to ensure that the evaluation and special education placement decisions are in compliance with prescribed standards. Inherent in the decision process is the need for the membership to be knowledgeable about the child. While these standards do not name specific educational personnel to be present, they do intend that the child's teacher (or at the secondary level, a representative of the child's teachers) be a member of the committee. For some students, this will be the regular education teacher; for some, the special education teacher; or, for others, representatives of vocational education and special education. The referring and receiving teachers should be in attendance. Adherence to the criteria of least-restrictive-environment must be observed.

2.8.1 Local education agencies shall establish one or more Educational Appraisal and Review Committees, each composed of no fewer than four individuals.

2.8.2 The committee shall meet as a whole and be composed of individuals directly involved with providing educational and ancillary services to the students as well as individuals knowledgeable in diagnosis and program planning for the areas of the child's suspected exceptionalities. A member of the evaluation team (e.g., speech-language pathologist, audiologist, diagnostician, coordinator of the diagnostic process) must be present at the initial placement review. Staff members acquainted with the needs of the linguistically different child shall serve on the committee when appropriate. The child's parent(s) and the child (when appropriate) shall be invited to participate in all Educational Appraisal and Review Committee meetings.

The school nurse provides medical and nursing assessment data and facilitates any additional medical evaluations when necessary. The school nurse will need to facilitate the flow of special education referrals and assessments so that the nurse can participate in the process effectively. School nurses need to become acquainted with personnel responsible for special education evaluations both at the building and district levels.

Screening Tests for Special Education

Vision Screening

Vision screening is needed to detect difficulties of vision acuity. Vision screening shall include distance visions, stereopsis, motility, and color discrimination.

Refer to vision screening section for specific tests and procedures.

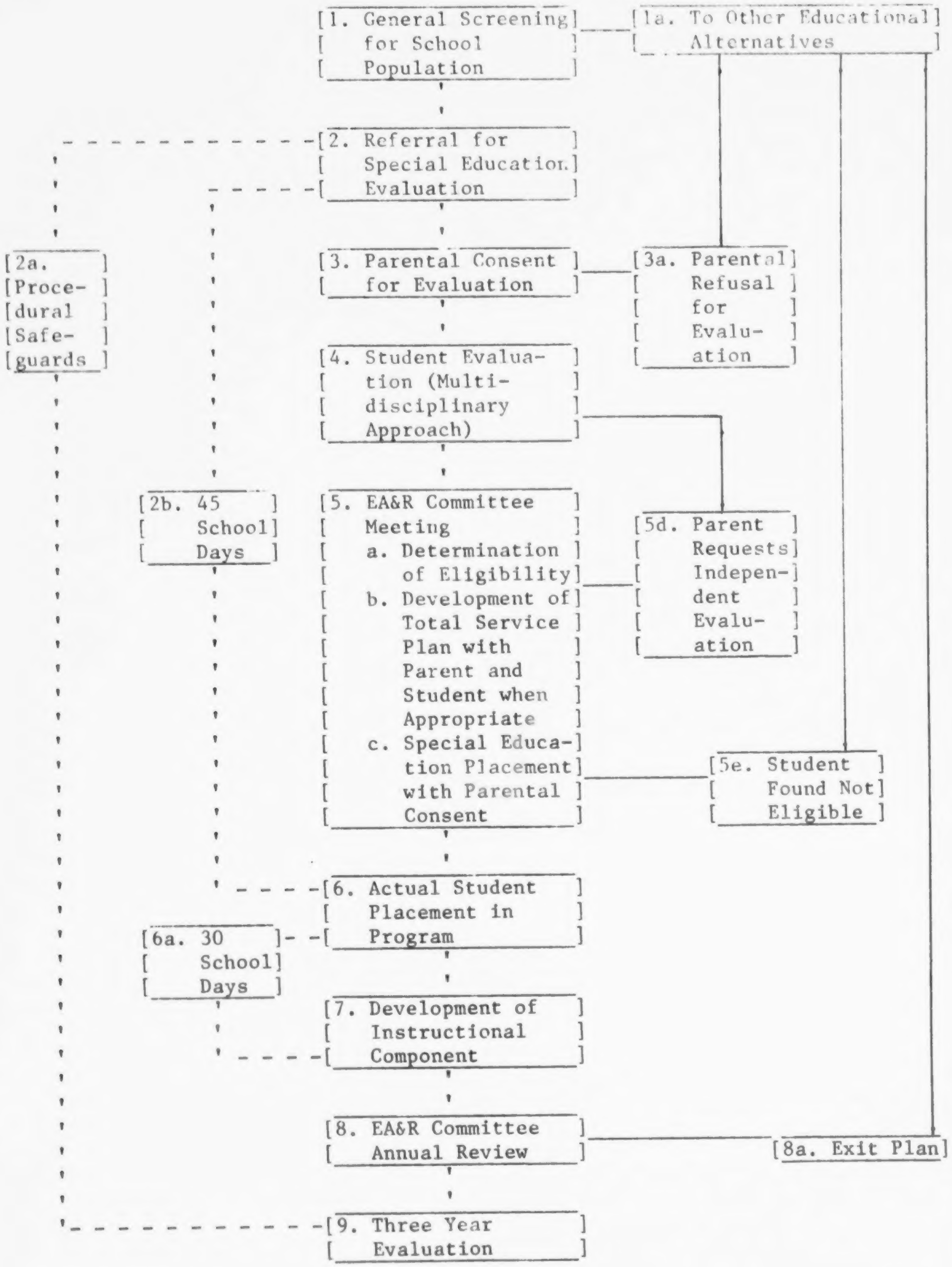
Hearing Screening

A pure-tone audiometric assessment should be conducted of at least the frequencies in the speech range (500 Hz - 4000 Hz). Refer to hearing screening section for guidelines.

NOTE: All children being referred for a special education evaluation must be screened by a certified school nurse.

NOTE: Check with your local school district for the special education placement process.

ELIGIBILITY/PLACEMENT PROCESS FLOWCHART


1. General Screening for School Population
1a. To Other Educational Alternatives
2. Referral for Special Education Evaluation
2a. Procedural Safeguards
2b. 45 School Days
3. Parental Consent for Evaluation
3a. Parental Refusal for Evaluation
4. Student Evaluation (Multidisciplinary Approach)
5. EA&R Committee Meeting
a. Determination of Eligibility
b. Development of Total Service Plan with Parent and Student when Appropriate
c. Special Education Placement with Parental Consent
5d. Parent Requests Independent Evaluation
5e. Student Found Not Eligible
6. Actual Student Placement in Program
6a. 30 School Days
7. Development of Instructional Component
8. EA&R Committee Annual Review
8a. Exit Plan
9. Three Year Evaluation

Eligibility/Placement Process Flowchart Narrative

1. General Screening

Educational Agencies are required to develop a system for screening the general school population in order to locate students who have special needs. Based on screening findings, other educational alternatives may be considered and recommended. [SSE 2.1(a), 2.2.1; BVS 7.1(a)(b); 34 CFR §300.220; NMSP FY 84-86, p. 20 (2a)]

1a. Educational Alternatives

Educational alternatives may include, but are not limited to, classroom modifications, referral to bilingual and chapter programs, and other alternatives that may be appropriate to meet the student's needs other than in Special Education. [SSE 2.1(a)]

2. Referral for Special Education Evaluation

Upon determination of a need for a special education evaluation, the eligibility/placement process begins. Tracking records regarding the referral process are maintained by Educational Agencies. [SSE 2.1, (b)(c) 2.3.1; 34 CRF §300.220; NMSP FY 84-86, p. 20 (2b)]

2a. Procedural Safeguards

Procedural safeguards begin with the initiation of a referral for a special education evaluation. Parents are informed of their right to request mediation and/or an impartial hearing. These safeguards may be initiated when concerns arise over local decisions regarding the identification, evaluation, placement, service provisions, or failure to provide services for a student. [SSE 3.2.1]

2b. Forty-Five School Days

Once the initial referral for Special Education evaluation has been made, the Educational Agency has 45 school days within which to evaluate and, if appropriate, place a student in a special education program. [SSE 2.6.8]

3. Parental Consent for Evaluation

An informed written consent must be obtained from the parents prior to evaluation. The notice must include a full explanation of all procedural safeguards, a description of the information used as a basis for the referral, and information regarding the diagnostic procedures to be used. [SSE 2.4.1, 2.4.2, and 2.4.3; 34 CFR §§300.500(a), 300.504(b), and 300.505]

3a. Parental Refusal for Evaluation

If the parent refuses permission for evaluation or placement, the eligibility/placement process is terminated unless the district initiates due process procedures. [SSE 3.2.1(d)]

4. Student Evaluation

(Multidisciplinary Approach) -- Once the parent has given written consent, the diagnostic evaluation process begins. Current pre-diagnostic information is collected and must include a summary of past educational and school health records, vision and hearing screenings, case history information, determination of the dominant language in the home, language proficiency assessment (if appropriate), and observational information of the student. When the pre-diagnostic information is obtained and reviewed, formal assessment is initiated by trained personnel as specified in Special Education Standards (e.g., educational diagnostician, speech-language pathologist, physical or occupational therapist). All diagnostic information is gathered and written into one summary. The Educational Appraisal and Review Committee is then convened to determine the student's status regarding eligibility. [SSE 2.1c, 2.5.1, 2.5.2, 2.5.3, 2.6.1, and 2.6.7; 34 CFR §§300.503, 300.531, and 300.532(a and f); NMSP FY 84-86, p. 54 (No. 8)]

5. Educational Appraisal and Review Committee Meeting

The student's parents must be given prior notice of the scheduled EA&R committee meeting and be invited to be active participants. The Committee is composed of the invited parent(s) and student (if appropriate) and individuals who are knowledgeable about the student, diagnosis, and program planning. These individuals are responsible for ensuring that the evaluation and special education placement decisions are in compliance with prescribed standards. Prior to the EA&R Committee meeting, all pre-diagnostic information, evaluation data, assessment summary reports, and other material resources, such as computer-assisted recommendations, books, manuals, or other objective banks of information are gathered for consideration by the committee. [SSE 2.4.1, 2.8.2]

5a. Determination of Eligibility

The Educational Appraisal and Review Committee will determine the child's eligibility for special education based on exceptionality and whether the student is in need of special education services. [SSE 1.3.2]

5b. The Total Service Plan

The Total Service Plan is developed during the EA&R Committee meeting with parents and the student, when appropriate, as active participants. It is not permissible for committee members to present a predetermined Total Service Plan to the parents for their approval before there has been a full discussion with the parents at the meeting. Members may come to the meeting prepared, for discussion purposes, with evaluation findings, related service needs, statements of present levels of educational performance and recommendations regarding annual goals and short-term objectives (general milestones developed from the annual goals).

5. 5b. Continued

Educational agencies may use commercially or teacher/agency prepared goals and objective banks (whether developed as software for microcomputer generation, or in book, manual, or other format) to assist in developing goals and objective recommendations for discussion at the meeting. All information is discussed at the meeting, and parents are afforded the opportunity to include their recommendations in finalizing the Total Service Plan. [SSE 2.10.1; 2.10.2, and 2.10.3; 34 CFR §300.346; NMSP FY 84-86, p. 24]

5c. **Special Education Placement**

Parental written consent must be obtained prior to initial special education placement or to any exceptionality or program level change. Placement shall be in the least restrictive educational setting so that peer interaction is appropriate to the exceptional student's needs. [SSE 2.9.1, 2.9.2, 2.12.1, and 2.12.2; 34 CFR §300.345; NMSP FY 84-86, p. 25-26.]

5d. **Parent Requests Independent Evaluation**

A parent has the right to request an independent educational evaluation at public expense. The educational agency may initiate an impartial hearing if the agency deems its evaluation appropriate. [SSE 2.6.7, 2.6.7(a)(b)(c)(d)]

5e. **Student Found Not Eligible**

If a student is found to be not eligible for special education service(s) the educational agency will consider other educational alternatives. [SSE 2.6.2]

6. **Actual Student Placement in Program**

The student is to be educated in the school which the student would normally attend if not exceptional except when the Total Service Plan calls for some other arrangements. [SSE 2.9.1, 2.9.2]

7. **Development of Instructional Component**

The instructional component is based upon the annual goals and short-term objectives established in the Total Service Plan and is developed by the personnel designated as being responsible for the special services the student is to receive. The use of commercially developed materials, such as textbooks, instructional kits, computer-assisted instructional programs, or teacher-developed instructional packages to aid in the development of logically sequenced instructional objectives, is appropriate. Modifications necessary for the student's participation in regular curricular or extracurricular activities, instructional methods, and timelines for evaluating each objective are included in this component. [SSE 2.10.4; NMSP FY 84-86, p. 25]

8. **Educational Appraisal and Review Committee Annual Review**

A review of the Individualized Educational Program is conducted at least annually and the parent is notified to attend. If there is a change in the student's program level or exceptionality, written parental consent is again required. If the parent does not attend the EA&R committee meeting and no change in service level is recommended, the parent may be notified in writing of the continuation or termination of special education placement. [SSE 2.11.1, 2.12.1, and 2.12.2]

8a. **Exit Plan**

When the student is able to meet all specific goals and objectives and is able to maintain educational performance in the basic program, the EA&R committee develops an exit plan permitting the student to return to a full-time regular classroom program. SSE 2.11.1; 34 CFR §300.552; NMSP FY 84-86, p. 82]

9. **Three Year Reevaluations**

Every three years, or when an exceptionality change is considered, the evaluation process is re-initiated. Informed written parental consent for reevaluation is obtained.

The reevaluation that is administered is specific to the student's exceptionality. Evaluation areas that are excluded are listed along with the rationale for their exclusion in the diagnostic summary. The process continues as per the eligibility/placement flowchart. [SSE 2.13.1, 2.13.2, and 2.13.3; 34 CFR §300.534; NMSP FY 84-86, p. 56 No. 5]

LEGEND: Congressional Federal Register, Public Law 94-142 Implementing Regulations [34 CFR §300]
New Mexico Basic and Vocational Standards 1984 [(BVS)]
New Mexico Standards for Special Education 1984 [SSE]
New Mexico State Plan, FY 84-86 [NMSP, FY 84-86]

RECOMMENDED POLICY GOVERNING ADMINISTRATION OF MEDICATIONS AT SCHOOL

Introduction

As stated by the American Academy of Pediatrics' Committee on School Health: "Ideally, all medication should be given at home. If medications are to be given during school hours, the school board should provide a clearly defined policy in this area. It is recognized that at the present time many children are able to attend regular school because of the effectiveness of medications in the treatment of chronic disabilities and illnesses" (Pediatrics 61:115-116, 1978).

Options for Taking Medications at School

1. Self-Administration

Older students may be allowed to assume responsibility for administration of their own medications, provided that self-administration is recommended, in writing, by the prescribing physician and the parent/guardian. The child must be instructed by the parent or physician on how to take his/her medication.

The parent/guardian must communicate with the school nurse. It is recommended that only one day's supply of medication be taken by the child to school each day.

2. Administration by the Nurse

In some cases, a school child will be considered either too young or otherwise incapable of reliability in taking his/her own medication. In this situation, an arrangement should be worked out with the school nurse so that the nurse may administer the medication to the child. Clear and explicit written communication among physician, parent, and school nurse is essential in such cases.

The container with the medication must be labeled with the name of the drug, the strength and correct dosage schedule for administration, the name of the student, and the name of the physician. Medications must be kept in a central location within a locked closet or cabinet. The young child and the handicapped or retarded child should be taught, according to level of ability, why he/she takes the medicine and according to what schedule it should be given.

Recommended Policy Governing Administration of Medications at School
Continued

3. **Supervised Self-Administration**

   In some cases, a school nurse is not available to administer a medication to a child who is either too young or is otherwise incapable of reliably taking his/her medication. In these special cases, the following approach is acceptable if the child in fact requires the medication in order to remain in school and must take the medication during school hours. The parent must give the child's teacher or other authorized person a sealed envelope containing the child's name, the name of the medication, and the date and time to be taken. The teacher or other authorized person will give the envelope to the child and instruct him/her to take the medication at the specified time.

It is to be recognized that options one and two are to be preferred, option three being reserved for situations where no alternative exists. A combination of options two and three may be appropriate when a school nurse is present on some, but not all, days. In all options, it is essential that the school nurse be notified of all students taking medications at school.

See Appendix for sample forms.

This policy was adopted by the New Mexico State Board of Education on March 26, 1982. Each local education authority must adopt a policy to meet local needs.

CARE OF EMERGENCY SICKNESS OR INJURY - FIRST AID

Every school should have a planned, written policy for the care of emergencies. Recommended emergency and first-aid procedures are available from the State Department of Education.

Adequate first-aid supplies should be checked and restocked periodically, kept to a minimum essentials, and made readily available in several easily accessible places in case of need. A copy of the current American Red Cross First-Aid Textbook should be kept with the first-aid kit and should be consulted for major first-aid procedures.

Some plan for mass disaster (e.g., fire; flood; windstorm; explosion; and nuclear attack, including blast, fallout, and fire storm) should also be provided. When the policies have been completed, they should be approved by the local school board.

In case of accident or sudden severe illness, the school has the legal responsibility for 1) giving immediate first aid (and isolation if the pupil is ill); 2) notifying parents; 3) making appropriate referral; and, 4) arranging for transportation to home, to a physician, or to a hospital when necessary. Treatment and after-care are the responsibility of the family and the family physician and dentist. No sick or injured child should ever be sent home alone, or sent home at all unless it is known that there is someone at home who can care for the pupil when he/she arrives.

Parents of pupils who have special health problems which might create a classroom emergency (e.g., epilepsy, heart trouble, diabetes), should inform the school about the problem as soon as possible, and should indicate any special instructions for the child from the attending physician which would involve the school. Children who have diabetes should carry or wear a diabetes identification card or tag.

Everyone on the school staff should have the skills and understanding necessary to give first aid. A standard American Red Cross first-aid course is strongly recommended. As a minimum standard, at least two persons other than the nurse should be well-trained in first aid and should be available at all times in each classroom building. Also, there should be a physician present or "on call" during every school athletic contest and practice session to take care of emergencies.

In a district where a nurse must provide transportation for students or himself/herself, the primary provider of insurance coverage must be aware of this additional responsibility. Liability insurance is usually provided by the local education authority as a secondary provider.

Rules for Use of First-Aid Kit

1. Wash hands before handling supplies.
2. Cleanse equipment and replenish supplies after use.
3. Check the contents of the kit periodically, at least once a month.
4. Each classroom can be provided with a simple first-aid kit and have children encouraged to use it.

Suggested First-Aid Supplies for the Nurses' Room

- Cotton Balls
- Paper Cups
- Ice Bag or Cold Packs
- Baking Soda
- Alcohol
- Mild Soap (1 bar)
- Adhesive Tape
- Splints
- Roller Bandage (1", 2" and 3" - 2 each)
- Thermometers (oral)
- Unmedicated Bandaids
- Table Salt
- Kleenex
- Paper Towels
- Tweezers
- Tongue Blades
- Cotton Applicators
- Safety Pins
- Sterile Gauze Squares
- Triangle Bandages (37" x 37")
- American Red Cross Book (First Aid - latest edition)
- Scissors
- Vaseline
- Syrup of Ipecac (for use following consultation with Poison Control)

See local District Health Officer for standing orders.

COMMUNICABLE DISEASE PREVENTION AND CONTROL

School health personnel have a vital role in the prevention and control of communicable diseases. Responsibilities in this area include: ensuring adequate immunization of all students in accordance with the guidelines of the Health and Environment Department; prompt reporting of communicable diseases; and assisting in the design and implementation of disease control strategies for school populations.

The New Mexico Immunization Law

New Mexico state law requires that all students be immunized against certain diseases. In 1978, a "Procedural Manual for Enforcement of School Immunization Law" was published by the Department of Education and the Health and Environment Department. This manual describes the legislative basis, the pertinent regulations, and the process through which the mandatory immunization program is to be carried out. Familiarity with the contents of this manual is essential for personnel involved with the school immunization activity.

The current requirements of the Health and Environment Department involve polio, measles, rubella, diptheria, pertussis, and tetanus vaccines. All of these vaccines are not required for every school child; refer to the most recent official schedule of the Health and Environment Department for specific age and sex requirements for these vaccines. (Schedules for each school year are published in April or May preceding the start of the year.) While mumps vaccine is not yet required by the Health and Environment Department, it is still recommended.

The importance of maintaining high immunization levels in the school children cannot be overemphasized. The excellent immunization levels in the school-aged population in recent years has been responsible for saving lives; preventing thousands of unnecessary illnesses; preventing needless hospitalizations, medical visits, and medication bills; preventing mental retardation and other serious complications of disease; and avoiding the loss of many thousands of school days due to illness. New Mexico has one of the best immunization records in the country -- an achievement which is attributed to excellent work by all members of the school and health systems.

The school nurse should determine which children require immunization and should notify parents and/or guardians.

The Reporting of Communicable Diseases

School personnel play an important role in detecting communicable disease problems in the community. Since many communicable diseases affect school-aged children, schools are excellent "early warning" sites for recognition of communicable disease problems. It is, therefore, quite important that school personnel recognize their responsibility in reporting communicable disease activity to Health and Environment Department personnel so that rapid corrective disease control actions can be taken.

In addition, school personnel have a legal responsibility to report communicable diseases. The current "Regulations Governing the Control of Disease and Conditions of Public Health Significance," adopted in December, 1979, state the following:

> "Any other person, including all persons listed in Section 600.12 of these regulations, having knowledge of any person having or suspected of having a notifiable disease, when no health care professional is in attendance, shall immediately report the instance to the Health Service Division."

The persons listed in Section 600.12 include "the principal or person in charge of any private or public school, or child care center, teachers and school nurses."

Copies of the list of "notifiable diseases" are available from the Office of Epidemiology, New Mexico Health and Environment Department, P.O. Box 968, Santa Fe, NM 87504. The list includes all of the vaccine-preventable diseases, plus other diseases and conditions of public health importance. The following list is representative, but not inclusive, of all these diseases and conditions: botulism, food poisoning, meningococcal disease, plague, typhoid, measles, rubella, polio, diptheria, tetanus, pertussis, hepatitis, salmonella, shigella, venereal diseases.

In most cases, disease reports are called in to the local field office of the Health and Environment Department by the school nurse. The purpose of disease reporting includes disease surveillance and disease control.

The Control of Communicable Diseases

Given the importance of communicable diseases to public health, the Health and Environment Department would rather receive initial reports of suspected illnesses, rather than waiting for reports of laboratory-confirmed illnesses only.

When a student or school employee becomes ill with a suspected communicable disease of public health importance, he or she should be seen by a physician. Based on the physician's diagnosis, along with the impressions of the school nurse, a report should be made to the local field office of the Health and Environment Department.

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A "Communicable Disease Manual" has been designed by the Health and Environment Department and printed by the Department of Education. This manual is essential for evaluation of the public health importance of specified communicable diseases. The manual describes relevant aspects of the disease and describes the basic tenants of a disease control strategy which may be indicated for the control of the particular disease. Additional copies of this manual are available from the Department of Education.

Under certain circumstances, an aggressive disease control strategy implemented by the Health and Environment Department may require the participation of school health personnel. Examples include outbreaks of measles or rubella among school children. The details of these investigations and disease control activities will be worked out on an individual basis, but close coordination and good two-way communication between school and health department personnel is essential and must be maintained.

Finally, questions or reports which school personnel would like to transmit directly to the Disease Control Unit in Santa Fe can be transmitted in three ways:

1. Call the toll-free number, 1-800-432-4404. Your message will be recorded. This is not a good system for emergency reporting.
2. Call the regular number, 827-3201. This is also a 24 hour, 7-day a week number, linked to an answering service. This is the number to call for any urgent or emergency situation requiring rapid response. If the need arises, do not hesitate to call this number.
3. Write to the following address:

Office of Epidemiology
New Mexico Health and Environment Department
P.O. Box 968
Santa Fe, NM 87504

Tuberculosis Control

The following are recommendations for tuberculosis control:

1. School personnel, including bus drivers, need a health certificate only upon entering employment with a school system. This certificate verifies an examination of tuberculosis has been conducted. The examination shall consist of a tuberculin test (of the Mantoux type, using PPD, 5 TU) followed by a chest X-ray for persons with a significant reaction to this test. Two-step PPD testing is recommended for all new employees over 50 years of age. Tuberculosis examinations are only required once for school employment in the state. It is recommended that school districts retain tuberculosis health certificates and/or give the certificates to employees transferring to other parts of the state to avoid duplication of unnecessary tests.

2. School personnel with X-ray changes compatible with tuberculosis will be referred to the local Field Office of the Health Services Division, HED, for further evaluation and, if indicated, treatment. Those found to have tuberculosis in a communicable form must stay away from school until proven to be noncontagious.

3. School personnel with evidence of tuberculosis infection (i.e., positive PPD only) should be urged to take chemoprophylaxis unless contraindicated. However, noncompliance with chemoprophylaxis shall not be cause for dismissal.

4. It is not generally recommended that students entering school be screened for tuberculosis. The prevalence of tuberculosis in this age group is very low and, therefore, screening tends to be unproductive. If a school system feels that entering students are at a higher risk for tuberculosis, then such a screening program may be instituted as a local option.

5. School children diagnosed as having "active primary" tuberculosis should be placed under the care of private physicians and/or public health professionals, and kept from attending school only if there is evidence of their being contagious (or seriously ill). School personnel and parents should be advised that most commonly these children are noninfectious and pose no risk to other members of the school community.

6. In health education activities, tuberculosis may be used as an example for infectious diseases which once caused a tremendous toll in suffering, disability, and premature death but which have come under control due to improved living conditions, advances in medical technology, the introduction of sophisticated public health measures, and the development of effective antimicrobial drugs. Students should learn that tuberculosis is still with us, but has become a relatively rare disease (presently about 125 new cases per year in New Mexico) which can be treated successfully once recognized in a person.

Notifiable Diseases/Conditions in New Mexico

Emergency Reporting

The following diseases, confirmed or suspected, require immediate reporting by telephone to the Epidemiology Office (827-3201).

A. Communicable Diseases

1. Vaccine-Preventable Diseases

    Diptheria
    Measles
    Pertussis
    Poliomyelitis
    Rubella
    Tetanus
    Serious or life-threatening vaccine reaction

2. Other

    AIDS (Acquired Immunodeficiency Syndrome)
    Botulism
    Infant Botulism
    Food Poisoning
    Haemophilus influenza (type b) infections (invasive)
    Meningococcal infections
    Plague
    Psittacosis
    Rabies, human or animal
    Tularemia
    Typhoid Fever (cases and carriers)
    Waterborne-Disease Outbreaks
    Infectious-Disease Outbreaks of Public Health Importance
    Noninfectious Conditions of Public Health Importance

3. Rare in New Mexico

    Anthrax
    Brucellosis
    Cholera
    Leptospirosis
    Q Fever
    Trichinosis
    Yellow Fever

Emergency Reporting, Continued

B. Environmental Health Problems

Human health problems related to:

- Water quality (bacteriologic or chemical/toxic contamination)
- Air quality
- Radiation exposures (natural or man-made)
- Toxic chemical exposures
- Food quality (bacteriologic or chemical/toxic contamination)

C. Occupational Health Problems

Illness related to the workplace.

Routine Reporting

Report to Epidemiology Office via toll-free number (1-800-432-4404) or to local health office.

- Amebiasis
- Campylobacter Infections
- Coccidiodomycosis
- Colorado Tick Fever
- Congenital Rubella Syndrome
- Cysticercosis
- Echinococcosis
- Encephalitis/Meningitis
- Giardiasis
- Hepatitis
  - A; B; Non-A; Non-B;
- Kawasaki Syndrome
- Legionnaires' Disease
- Leprosy
- Malaria
- Murine Typhus
- Relapsing Fever
- Reye Syndrome
- Rocky Mountain Spotted Fever
- Salmonellosis
- Shigellosis
- Toxic Shock Syndrome

Written Reporting

Contact the local health office.

- Chancroid
- Gonorrhea
- Syphilis
- Rheumatic Fever
- Tuberculosis
- Cancer - Report directly to:

New Mexico Tumor Registry
900 Camino de Salud NE
Albuquerque, NM 87131

All Reports Include

1. The disease or problem being reported.
2. Patient's name, age, address, and telephone number.
3. Physician's (or laboratory's) name and telephone number.

HED Regulation HED--79-4(HSD) Section 700.01 March, 1984

Regulations Governing the Control of Disease and Conditions of Public Health Significance

(HED 79-HSD-4)

General Provisions

100 Legal Basis. The regulations set forth herein are promulgated by the Secretary of Health and Environment by authority of Section 9-7-6(E) NMSA 1978 and in conformity with the Public Health Act, particularly Sections 24-1-2, 24-1-7, 24-1-8, and 24-1-15, NMSA 1978. Administration and enforcement of these regulations is the responsibility of the Health Services Division of the Health and Environment Department.

200 Scope. All physicians, laboratories, health care professionals, and other persons having knowledge of disease or illness covered by these regulations.

300 Purpose. The essential principle in the control of communicable diseases is prompt identification of disease, notification of responsible health authorities, and institution of preventive and ameliorative measures.

400 Guidelines. In the absence of specific direction in these regulations, the following are recognized as guidelines:

400.01 The current publication of the American Public Health Association, Control of Communicable Diseases in Man.

400.02 The current report of the Committee on Infectious Disease of the American Academy of Pediatrics.

400.03 Appropriate standards of the Center for Disease Control, USPHS.

400.04 Internal Health and Environment Department protocols, such as those established for venereal disease control are also guidelines.

500 Other Regulations. These regulations are subject to the provisions of the Health and Environment Department's Regulations Governing Promulgations of Regulation and Regulations Governing Public Access to Department Records. In addition, certain public health functions, not treated herein, on which regulations are now or hereafter may be in force, must be considered when interpreting these regulations: prevention of infant blindness; newborn screening for phenylketonuria and other congenital malfunctions; premarital testing and compulsory student immunization. Copies of regulations may be obtained by writing to the Health Services Division, P.O. Box 968, Santa Fe, NM 87503.

600 Definitions. As used in these regulations, the following terms shall have the meaning given to them, except where the context clearly requires otherwise.

600.01 "Carrier" means an infected person or animal that harbors a specific infectious agent without clinical symptoms and that serves as a potential source of infection for humans.

600.02 "Condition of public health significance" means a non-communicable disease caused by a common source or prevalent exposure. Example of such conditions are: carbon monoxide poisoning, heavy metal poisoning, and pesticide poisoning.

600.03 "Communicable diseases" means an illness caused by infectious agents or their toxic products which may be transmitted to a susceptible host.

600.04 "Communicable period" means the period during which the infectious agent may be transmitted directly or indirectly from the body of the infected person or animal to a human.

600.05 "District Health Officer" means the physician designated by the division to be responsible for all state public health activities in any health district.

600.06 "Division" means the Health Services Division of the Health and Environment Department of the State of New Mexico, P.O. Box 968, Santa Fe, NM 87503.

600.07 "Epidemic" means the occurrence of a number of cases of an illness in a community or region which clearly exceeds normal incidence.

600.08 "Incubation period" means the period between exposure to a disease organism and the onset of clinical manifestations.

600.09 "Isolation or Quarantine" means the complete separation or partial restriction of movement and association in such manner and for such period as will prevent the direct and indirect transmission of the infectious agent.

600.10 "Laboratory" means the Scientific Laboratory Division of the Department or any other laboratory approved by the Scientific Laboratory Division to perform diagnostic tests for diseases and conditions covered by these regulations.

600.11 "Notifiable Disease" means a communicable disease or condition of public health significance required by statute or these regulations to be reported to the division.

600.12 "Other person" includes but is not limited to: a laboratory; an official in charge of any health facility; hospital records or administrative personnel; the principal or person in charge of any private or public school, teachers, and school nurses; and any householder or any other person, in the absence of a physician, having direct knowledge of communicable disease or condition of public health significance.

600.13 "Health care professional" means any licensed doctor of medicine or osteopathy, nurse, physician's assistant, or midwife unless the context clearly requires otherwise.

600.14 "Report" means a notification to the division which indicates the disease being reported, the patient's name, age, sex, address, and telephone number, and the physician's name and telephone number.

600.15 "Specimen" means any materials derived from humans or animals for examination for diagnosis, prevention, or treatment of any communicable disease condition of public health significance.

Notifiable Diseases

700 Declaration of Notifiable Disease. The division shall periodically issue an index of notifiable diseases according to reporting category. The index shall be reviewed at least annually and revised as necessary. Diseases shown on Exhibit A to this regulation are declared notifiable diseases as of the effective date hereof.

800 Official Listing. The index of notifiable diseases shall be issued in a quick reference format and shall show that it is the current official list and shall specify its effective date. The division shall routinely supply the current official index to physicians and health facilities and to other persons or entities on request.

900 Reporting of Notifiable Diseases. Reporting will be by means of:

900.01 The Division's 24-hour telephone number as listed in the "Communicable Disease Summary," the division's monthly newsletter to physicians, or direct telephone contact with the district health officer;

900.02 Written report to the division.

1000 Reporting Requirements - Physicians. Every health care professional treating any person suffering from or suspected of suffering from any notifiable disease or other condition of public health significance shall report the same within the time and in the manner set out in the index of diseases.

1100 Reporting Requirements - Laboratories. All laboratories performing diagnostic tests for any notifiable disease or other condition of public health significance shall report all positive findings within the time and the manner set out in the index. Reports shall include the name of the reporting laboratory, the patient's name and address, the date of clinical diagnosis, and the physician or hospital requesting the test.

1200 Reporting Requirement - Other Persons. Any other person, including all persons listed in Section 105(L) of these regulations, having a notifiable disease, when no health care professional is in attendance, shall immediately report the instance to the division.

1300 Conditions of Public Health Significance. Any person, including health care professionals and persons listed in Section 105(L) of these regulations, who has knowledge of the occurrence of other conditions of public health significance shall immediately report the circumstances to the division.

Control of Diseases

1400 Responsibility for Protection of Public Health. The division may take such measures on the advice of its medical officer or officers as are deemed necessary and proper for the protection of the public health.

1500 Coordination Among Agencies. The division shall coordinate the efforts of other concerned or interested federal, state, and local agencies and shall cooperate with local physicians and health care facilities.

1600 Imposition of Isolation or Quarantine. The division may establish isolation or quarantine as to any animal, person, institution, community, or region.

1700 Case Incidence in Schools or Health Facilities. Where case of communicable disease occurs or is likely to occur in public, private, or parochial school or in a licensed health facility, including child care facilities, the division may require:

1700.01 Exclusion of infected persons and nonimmune persons whether students, patients, employees, or other persons;

1700.02 Closure and discontinuance of operations if there is likelihood of epidemic.

1800 Isolation - Escape or Refusal to Submit. When a person for whom isolation has been required refuses to submit to such isolation, the division may, pursuant to Section 24-1-15 NMSA 1978, seek the arrest and involuntary hospitalization of such person.

1900 Other Public Health Orders. The division may issue orders for the testing of particular populations or groups of persons or animals to identify carriers of disease, including immigrants, travelers, and others who have been at risk of exposure. The division may require that all tests be done by or under the control of the Scientific Laboratory Division or by a laboratory approved for the purpose by the Scientific Laboratory Division.

2000 Enforcement of Public Health Orders. Any order issued by the division under the Public Health Act or these regulations shall be enforceable as provided by law and violation is punishable in accordance with Section 24-1-21, NMSA 1978.

2100 Repealer. These regulations repeal and supersede all previous regulations, particularly regulations governing the control of communicable disease of November 11, 1952, and regulations governing the reporting of notifiable disease of June 29, 1974.

SAFETY PROGRAM

Accidents are the leading cause of death and disability of school-aged children. The role of the school safety education program in providing sound backgrounds for the prevention of accidents is highly compatible with the objectives of general education.

A desirable safety program would provide a safe school environment as well as learning experiences in many areas which would equip the individuals with knowledge, understanding, and the ability to reduce the possibility of accidental injury or death throughout their lives.

Organization and Administration

The following are suggested steps in the organization and administration of school safety programs:

1. The responsibility for the organization, direction, and supervision of the safety education program should be assigned to one individual. Active support by the administration and cooperation of staff are essential to an effective program.
2. Identify the specific, existing school safety and accident problems; identify school safety hazards and accident-prone pupils; encourage pupils to participate in these fact-finding procedures.
3. Determine resources (teaching aids, personnel, funds, etc.).
4. Set priorities based on problems found and work on them one at a time (may vary from grade level to grade level and from school to school); add new policies as needed; and encourage pupils to participate in the planning procedures.
5. Evaluate the program periodically and make changes as needed.

Objectives and policies should be established for faculty and pupils to follow.

Policies should be comprehensive in scope and should include among other factors:

1. Guidelines for physical education and athletics which, among other things (a) recognize the importance of medical examinations and adequate physical conditioning prior to strenuous activity, and (b) will not jeopardize children who have health handicaps or children who are undergoing radical physical changes during puberty.

2. Safe, well-equipped, properly supervised playgrounds are a necessity, not a frill. Equipment and play areas should encourage physical activity, the development of coordination and strength, as well as cooperative play. Particular attention must be paid to providing appropriate surfacing materials -- especially under playground equipment. (Sand beneath equipment provides a good cushion to prevent injuries.) Children of different age levels should not be allowed to participate at the same time, and too many children should not be allowed to overcrowd limited facilities. The local school administrator shall assign someone to regularly check equipment and evaluate it to make sure it is safe, in good repair, and appropriate.

3. Provision that facilities and equipment for recreation, athletics, shop, and science classes should be basically and functionally safe, properly installed and fitted, and their use should be properly supervised at all times. School shops, laboratories, and workrooms should have adequate intake and exhaust ventilation, emergency showers, and readily available fire control equipment. All machinery should be equipped with appropriate safety devices and, where appropriate, operators should wear protective gloves, goggles, shields, and clothing. A first-aid kit should also be available to these areas.

In-service education of faculty and other school personnel is needed in regard to clarifying the role and responsibilities of each person in the school safety program, as well as to provide an understanding of the overall program.

Safety Education

Both the school and the parents should keep in mind the danger of overprotecting children. Each child should be helped to enjoy new experiences while developing skills to cope with the hazards involved. Emphasis should be placed on instilling a good balance between adventure and rational caution and a realistic development of self-dependence. Therefore, we should teach children: (a) to recognize and have a healthy respect for dangers, (b) to distinguish between risks that may be taken and those which should be avoided, and (c) to know how to deal with dangers that cannot be avoided.

The many areas of safety education, as well as the method of instruction will obviously vary considerably, dependent upon interests, age groups, local conditions, and many other factors. Special areas of instruction would include: home safety; water safety; firearms safety; shop safety; safety in athletics; physical education and recreation; school bus transportation; and traffic safety, including seat belts and motorcycle helmets.

The most effective and productive safety education methods involve (1) active pupil involvement and participation (e.g., school safety council, safety patrol, learning new skills, etc.); and (2) use of classroom "problem-solving, decision-making" techniques.

Safety Program, Continued

The school should try to maintain a positive approach to safety education, i.e., teach pupils to learn safe habits and attitudes as a means of safely doing what we want to accomplish in life and not as ends in themselves. Major efforts in development of safe habits and attitudes should be concentrated in the primary grades, with topics geared to the interests and readiness of each of the grade levels involved.

Research indicates that many accidents result from a subconscious need to punish the self or others. Aggressive and hostile proneness is not an "either/or" proposition. It is all a matter of degree -- like mental illness.

Accident repeaters tend to have the same personality characteristics. They are impulsive, rude, hostile, quick-tempered, overly aggressive and bullying, highly egocentric and show-offs, and tend to be poor losers. Teachers need to identify pupils with such characteristics. Both teachers and parents should make a special effort to help such pupils to feel accepted and to maintain status with their peer groups, for this will help reduce the subconscious needs of these pupils to have accidents. Likewise, a good physical fitness program will enhance the safety program in that, among other things, it will provide a variety of socially acceptable outlets for aggressive and hostile feelings of pupils and will provide a means whereby pupils can ascertain their physical limitations and can improve their physical skills.

Parents should be encouraged, perhaps through the P.T.A., to reinforce the school's safety education program by means of safety instruction of pupils at home, setting a good example in regard to good safety habits and attitudes, and teaching their preschool children good safety habits that are compatible with the child's interests and readiness.

Fire Protection

State law requires a fire drill be held each week during the first month of school and at least once each month thereafter. In addition, the law authorizes the State Fire Marshal to prescribe rules and regulations for teaching proper methods of fire prevention and control.

Age and grade would determine the extent of instruction in regard to reporting a fire, proper use of fire extinguishers, detecting hazards, etc., but all should be familiar with evacuation procedures.

Noise Pollution

Noise pollution is an invisible hazard because you can't see its damaging effects as you often can with air or water pollution. Most teenagers probably are victims of noise pollution.

Sensory deafness, an incurable hearing loss caused by excessive noise over a long time, was detected in 60 percent of college freshmen in a recent survey. The damage began to show up in sixth-grade students and increased as they were exposed to years of environmental noise.

Effects of Noise Pollution

Noise loud enough to damage structures of the inner ear can cause varying degrees of permanent hearing loss; and annoying noise that is not loud enough to cause physical damage to the ear has nevertheless been shown to cause other physical and mental problems. Doctors' and psychologists' studies indicate that because noise can interfere with your rest and relaxation, it affects your general health.

The entire body reacts to noise. If the noise is sudden, you blink, tense your muscles, and may perspire. Blood pressure and cholesterol levels rise, pupils of the eyes dilate, heart and breathing rates increase, stomach acid increases, and hormones pour into the blood stream. Even when sound is not loud enough to cause permanent hearing loss, prolonged noise exposure causes stress that is linked to headaches, ulcers, and high blood pressure. When sleep is disrupted by noise, it causes fatigue and stress on body systems.

Sound levels in schools can affect students' ability to learn. One recent study showed that students whose classroom faced an elevated train track scored significantly lower on reading tests than students whose classrooms were farther away from the disturbing noise.

Sensory Deafness

Sensory deafness causes no physical pain. The noise you are exposed to does not need to be unpleasant -- like a jackhammer tearing up the street or an alarm clock -- to cause permanent damage to the inner ear. It can be the sound from your favorite rock group or a recording of a symphony orchestra. The source of the sound doesn't matter, just the loudness.

Sound is expressed in decibels, a unit that measures the intensity of sound. (It is abbreviated db.) Pain is caused by noises measured over 140 db, like an air raid siren or shotgun blast. The decibel level chart shows the levels of common environmental noise and people's reactions to it.

If the sound level is above 70 db, it can eventually damage your hearing. A recent random survey done on New York City streets measured the decibel level on headsets worn by pedestrians. The music was often measured by 120 db -- almost twice the level that can cause sensory deafness.

Noise Pollution, Continued

Noise at this decibel level damages the hair cells in the inner ear. Sound vibrations, loud or soft, travel through the outer and middle ear to the inner ear where they are picked up by the tiny hair cells and sent along the auditory nerve to the brain. This is where permanent damage occurs when sounds are too loud (over 70 db) over a long period. They spring back as long as the sounds are not too loud. After years of exposure to damaging sound levels, the hair cells do not spring back anymore; they stay flattened out and eventually they die. Noise can also cause sensory deafness, when it raises the temperature in the inner ear or creates a lack of oxygen, thus destroying hair cells.

The ears do not adjust to loud sounds, and hearing is permanently damaged. No medicine or operation can cure sensory deafness. Hearing aids are not much help for damage to the inner ear.

Warning Signs of Sensory Deafness

If this hearing loss is not painful, how can you tell if exposure to environmental noise has already damaged your hearing? Your ears may be giving you a hint that they're being overworked if they buzz or ring for a while after you listen to loud music; if noise gives you a headache; if you have to turn up the radio, television, or stereo when others in the room can hear it; or if you have trouble hearing people speaking to you. Students who notice some of these warning signs or think they do not hear as well as they used to, should ask their school nurse or doctor to give them a hearing test. If the test detects a hearing loss, they can prevent further damage to their hearing.

The School Environment

The physical environment of the school can affect the health of students and school personnel. Safe building construction, sanitation, lighting, ventilation, heat, acoustical characteristics, and food-serving facilities are all critical to the safety and well-being of anyone who uses the school facility. School officials are responsible for maintaining alertness to unsafe conditions and then for providing and maintaining every reasonable safeguard for the life and health of persons within the school setting.

School buildings should meet all local and state building, safety, and sanitation codes. Schools should be kept clean, free of vermin, and in good repair. Floors should have smooth, easily cleaned surfaces. All stairways and steps should have handrails and nonslip treads. Plumbing, especially, should be installed in strict compliance with the State Plumbing Code and kept in excellent repair. Adequate storage space for all hazardous compounds should be provided and used for no other purpose. Such storage should be located and designed so as to prevent contamination of foodstuffs and accidental or unauthorized use. All facilities should be designed or modified to provide access for handicapped persons.

Safe water supplies need to be available and provided in adequate volumes. Sufficient pressure should be maintained at all potable water outlets. Drinking fountains should be properly maintained and provided with mouth guards. It is especially important to provide proper hand washing facilities which are adequately stocked with soap and paper towels for all students and staff members to use. Besides providing such facilities in all toilets, they should be provided in special use areas such as food service areas, nurses' offices, home economics rooms, special education classrooms (if needed), library workrooms, etc.

All school buildings should be provided with waterborne sewage disposal systems. All sewage and liquid wastes should be discharged into a public sewer system where possible. If public sewers are not available, sewage and liquid wastes should be disposed of by approved methods. All schools should be provided with adequate, conveniently located toilet facilities. Separate facilities for each sex should be provided on each floor level of multiple-story buildings and in each distinct wing of a building. Additional toilet facilities properly located with respect to the gymnasium, public use rooms or facilities, food service facilities, staff personnel, and other special needs should also be provided. All group toilets should be provided with properly located floor drains, and floors should be graded to prevent standing water. Toilet paper in suitable dispensers should be conveniently located adjacent to each toilet and kept supplied. It is essential that adequate soap and paper towels be provided at all times to encourage proper hand-washing. Easily cleanable, impervious waste containers should also be provided in all toilet rooms. Adequate ventilation should be present in all toilet facilities.

THE HEALTH ROOM FACILITY

The health unit must be designed so that it will be appropriate for the particular school population. It should be adjacent to and entered by way of the school's central control area. The unit should include a nurse's office, locked storage space, first-aid area, reception or waiting area when appropriate, cot room or rest area for students, separate cot area for a teacher, and conference room.

The nurse's office must ensure privacy for conferences with students, parents, and school personnel, and be equipped with a desk, chairs, a bulletin board, a bookcase or shelving, a file cabinet, a wall clock, a private telephone, and electrical outlets. This area should be soundproof to facilitate audiometric testing. Each health unit will have a locked storage space where supplies and equipment can be kept.

The health unit's first-aid area should be private and equipped with a built-in sink, with cupboards above and below. The sink should have a mixing faucet high enough above the counter to allow for filling a ten inch basin. There should be dispensers for soap, paper towels, and paper cups. The rest room area must be included and equipped with hot (no more than 120° F) and cold running water and toilet facilities.

The cot room should be large enough to allow for three feet between the cots with screening to prevent cross infection. The number of cots in this area is determined by the character of the school population. The cots should be segregated by sex in the upper grades. Provision should be made for the teacher rest area.

The conference room should be shared with others, sized to accommodate up to 12 people, and equipped with a table and chairs.

Materials and Equipment

The supplies and equipment for the health unit are listed below:

- Audiometer (one per school)
- Stretcher
- Pamphlet rack
- Bulletin board
- Gooseneck lamp
- Refrigerator with ice supply
- Typewriter and duplicating machine (or access to this equipment)
- Tables for waiting area and conference room
- Special vision testing equipment if 20 linear feet of space is not available for vision testing (e.g., OrthoRator, Goodlite box and stand)
- First-aid supplies
- Paper cups, soap, towels, and dispensers
- Mending equipment
- Sanitary napkin dispenser in lavatory area
- Cots, blankets, pillows
- Chairs for nurse's office, waiting room, first-aid room, and one per cot
- Desk for nurse's office
- Record forms and office supplies as indicated
- Steel desk
- Card file
- Filing cabinet
- Telephone (private)
- Mirror (optional)
- Locked medicine cabinet

The Health Room Facility, Continued

All secondary schools conducting physical education programs should provide shower facilities for students. Showers should be equipped with automatic anti-scald temperature controls, and water temperature at the shower head should not exceed 120° F. Floors should be sloped towards drains enough to prevent standing water. Shower and drying room walls and floors should be finished with impervious, easily cleanable, nonabrasive materials up to the shower head height. If schools provide bath towels, such towels should be for individual use only, and should be subjected to an effective laundering process after each use. Shower facilities should also be provided with adequate ventilation.

It is the responsibility of the school administration to properly staff and supervise all functions essential to the safe and proper functioning of the school plant. Such functions include the operation of food service facilities, general maintenance, and custodial work, and, in some cases, water and sewage systems and solid waste disposal. In situations where serious sanitation problems exist, local administrators and health officials are charged with taking whatever measures are necessary to safeguard the well-being of students and staff. In addition to custodial personnel, the school nurse is encouraged to make frequent and routine environmental inspection in order to keep the administration informed of any problems. The school nurse and local health officials can provide the expertise concerning Public Health principles and should help the school administrators deal with environmental concerns in the school setting.

NEW MEXICO

COMMUNICABLE DISEASES MANUAL

1986

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Additional copies of the Communicable Diseases Manual are available from the New Mexico State Department of Education, Vocational-Technical Education Unit.

APPENDIX A

MANUALS

NEW MEXICO
HEALTH AND ENVIRONMENT
DEPARTMENT

Office of Epidemiology

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Harry F. Hull, M.D., State Epidemiologist

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Secretary

TEODORO "TED" GUAMBAÑA
Deputy Secretary

JOSEPH JOHNSON
Deputy Secretary

July 31, 1985

Dear School Nurse:

This book is the latest revision of the Communicable Disease Manual first produced by Dr. Jonathan Mann and Dr. Lance Chilton in 1977. The manual is intended to serve as a guideline for the understanding of communicable diseases that are commonly encountered by or are important to the practice of the school nurse. Because of the general nature of the knowledge in this manual, only minor changes have been made in the text. The most important of these changes is in the structure of the state health department. If you have questions or need consultation regarding communicable diseases, you should contact the Epidemiology Office in Santa Fe at 827-3201. Routine reports of communicable disease should continue to be made to your local county field health office of the Health Services Division.

I also wish to extend our thanks to all school nurses for the hard work that has gone into enforcing the school immunization law. New Mexico continues to have one of the best immunization programs in the country and the credit belongs largely to you, the nurses who have manned the front lines in the war against immunizeable diseases.

I hope that this manual will continue to be a useful reference for you. We welcome any comments on ways to make it more useful in your work.

Sincerely yours,

Harry F. Hull, M.D.
State Epidemiologist

COMMUNICABLE DISEASES MANUAL

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INTRODUCTION

This manual is designed to provide up-to-date and practical information on common communicable disease problems. We have selected a format which treats each disease entity separately. The placement of these sheets into a loose-leaf binder will permit additions or deletions to the manual as disease control information and practices change. Each disease entity is described as follows:

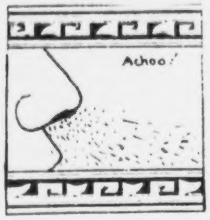
Name of Disease	Proper and commonly used names are included.
Infectious Agent	Name of the infectious agent, along with its categorization (viral, bacterial).
Clinical Description	The goal of this section is "how to recognize" the disease. In some cases, illustrations are used to supplement the text.
Diagnosis	The methods of diagnosis (both clinical and laboratory) are described, principally for background information.
Mode of Transmission	The common route by which the infection is transmitted.
Incubation Period	This term is defined in the glossary.
Infectious Period	This term is defined in the glossary.
Management of Case and Contacts	This section focuses on the practical questions of whether the case should be excluded from school (and, if so, for how long); how to manage both children and adults who have been in contact with the infected school child.
Preventive Measures	This is a brief description of preventive measures generally used to control the specific disease (i.e., immunization, isolation, medication, hygiene).
Public Health Importance	We believe that reporting of communicable diseases to public health authorities is a high priority for school nurses. Often, the school nurse is in an ideal position to detect the first appearance of communicable disease problems in the community. This section focuses on the reasons why reporting of the specific disease entity is important to the public health.

We welcome comments and suggestions on the manual. The manual will be updated as needed. In addition, further background information can be inserted into the manual as it becomes available.

GLOSSARY

Serology A disease can be diagnosed by measuring the levels of antibody against the disease. This method is especially useful for the diagnosis of viral diseases. In order to make a serologic diagnosis, two blood specimens are usually needed: the first early in the illness, and the second after the patient has recovered from the disease.

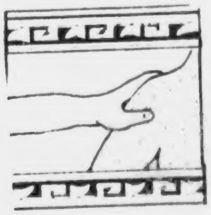
Modes of Transmission There are many ways in which an infectious disease can be transmitted from one person to another person.



Airborne When a person coughs or sneezes, respiratory droplets are propelled into the air. Certain diseases can be spread when an ill person coughs or sneezes -- susceptible persons coming into contact with these respiratory droplets may thereby become infected.

Fecal-Oral Transmission Some viruses and bacteria (as well as other infectious agents like parasites) are excreted in an infected person's stool. For this reason, contact with the fecal matter may transmit the infection. For example, if a child with Shigella goes to the bathroom, has a bowel movement, and does not wash his/her hands thoroughly, some of the fecal matter will remain on the child's hands. If the child now shares some food, or places his/her hand into another child's mouth, the disease-bearing fecal matter will be transferred. Obviously, strict hygienic measures can prevent this type of spread.

Foodborne or Waterborne Food or water can be contaminated by infectious agents, with resulting outbreaks of foodborne or waterborne illness. This type of transmission should be considered when many children become ill within a short time of each other.



Direct Contact Some diseases may be transmitted when one person comes into close contact with another person. Examples include: spread of chicken pox after contact with the early skin lesions of chicken pox; or spread of head lice between children.

Sexually Transmitted Disease While it is possible, under unusual circumstances, for syphilis or gonorrhea to be transmitted to a child through means other than sexual contact, any case of a sexually transmitted disease represents a case of possible child abuse and must be handled accordingly.

Modes of Transmission Continued

Fomites, or Spread via Inanimate Objects

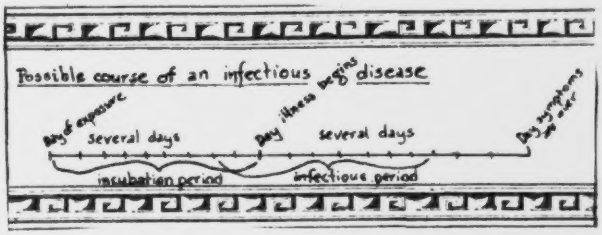
Some infectious agents have the ability to survive on surfaces. For example, if a stool contaminates a drinking cup or pencil, the shigella may survive long enough so that the persons drinking from the cup or sucking the pencil can acquire the infection. Another example would be bedding or scarves infested with head lice: a noninfested person sleeping in the bed or wearing the scarf from a louse-infested child would be likely to acquire the head lice.

Incubation Period

The incubation period is the time between exposure to a disease and the time that illness actually begins. For example, a susceptible person exposed to a case of measles will remain well for about 10 days. After this 10-day incubation period, the first symptoms of measles will begin. The incubation periods of different diseases may be quite variable, lasting from hours in some cases to weeks in others. Finally, some diseases can have a variable incubation period (i.e., the incubation period of rubella normally ranges from 14 to 21 days). See the illustration below for a timeline visualization of the incubation period concept.

Infectious Period

The infectious period includes the entire period of time during which a susceptible person may contact the disease from a case of the disease. It is vital to realize that people can be infectious before any symptoms begin. In addition, people often cease to be infectious before their symptoms are completely over. For example, a child with measles can be infectious to other people as long as 7 days before the rash appears, and for as long as 7 days after the rash has started. Knowledge of the infectious period is often quite important in the design of rational disease control measures.



Name of Disease	**ACQUIRED IMMUNODEFICIENCY SYNDROME (AIDS)**
Infectious Agent	Human T-cell lymphotrophic virus, type III (HTLV-III)
Clinical Description	AIDS is the most severe form of HTLV-III infection. Most persons who become infected with the virus remain perfectly well. Some will develop AIDS Related Complex (ARC), which may include symptoms such as low fever, night sweats, swollen lymph glands, and bleeding into the skin. About 10% of persons infected with HTLV-III will develop AIDS. AIDS is the result of the destruction of the immune system by HTLV-III and is manifested by opportunistic infections and certain cancers. Opportunistic infections are caused by organisms that would normally be destroyed by the body. The most common one in AIDS is *Pneumocystis carinii* pneumonia. The most common cancers found in AIDS are Kaposi's sarcoma (a skin cancer that begins as blue-brown patches in the skin) and primary brain lymphoma. Most AIDS patients are so ill that they require hospitalization.
Diagnosis	The diagnosis of AIDS is made by the laboratory diagnosis of an infection caused by an opportunistic organism when the person has been previously healthy and there is no reason for the immune system to be abnormal. A positive HTLV-III blood test indicates only that the person has been infected with the virus and may be capable of spreading the infection to others. The HTLV-III blood test, by itself, does not indicate whether or not a person has AIDS.
Mode of Transmission	HTLV-III infection is spread primarily through sexual contact or through blood (including needles shared by drug users). There is no evidence that HTLV-III infection is spread by food, water, through the air, or by casual contact.
Incubation Period	Although HTLV-III antibodies can be found in the blood several weeks after exposure, AIDS does not become apparent until 2-5 years after the person has been infected with HTLV-III.
Infectious Period	More research needs to be done on the period of infectiousness, but the best evidence now is that most people become carriers of the virus and are capable of spreading the infection to others for many years.
Management of Contacts	Persons who have sexual or blood contact with persons infected with HTLV-III should be informed of their exposure and referred to their physician or the Health Department for counseling and possible testing.

Other School Children

Since AIDS is not spread through casual contact, there is no risk of spread in normal classroom situations. If parents of children in the same classroom as a child with AIDS question you about risk, they should be reassured.

Management of Cases

Persons with AIDS are severely ill and should be under the care of a physician. Between episodes of hospitalization, they may be well enough to return to school and should be allowed to attend classes normally unless the physician determines that the risk of catching opportunistic infections is too great. Children who are infected with HTLV-III and remain healthy should also be allowed to attend classes normally. Children who have AIDS or asymptomatic HTLV-III infection who have behavior problems (e.g., biting) that might result in transmission of the virus should not be allowed in the classroom. If a child with HTLV-III infection (with or without AIDS) should accidentally cut themselves, spilled blood should be cleaned up with a solution of 1:10 household bleach to kill the virus.

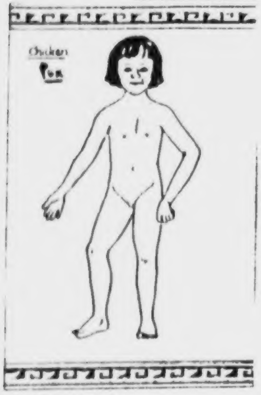
Preventive Measures

Homosexual males can reduce their risk of becoming infected by engaging in safe sexual practices including the use of condoms, particularly during anal intercourse. Intravenous drug use should be avoided especially when it involves the use of shared needles. Both heterosexuals and homosexuals with multiple partners are at increased risk of becoming infected. They may reduce their risk by reducing the number of their sexual partners and by using condoms during sexual intercourse.

Public Health Importance

AIDS is a new disease that is spreading rapidly in this country. As of January 1986, 73% of cases have occurred in male homosexuals and bisexuals and 18% in intravenous drug users. Hemophiliacs make up 1% of the cases. About 1% of the cases have been children. However, the infection can also be spread through heterosexual intercourse and this mode of spread may become increasingly important as time passes. Because there is no cure and no vaccine is available, health professionals must educate both the general public and members of high-risk groups about how the disease is spread and about methods of reducing the risk of becoming infected.

Name of Disease	**ANIMAL BITES**
Infectious Agent	Animal bites raise concern about bacterial infection, including tetanus, and rabies (a viral disease).
Clinical Description	The bite is obvious. It is vital to collect the following information: the type of animal involved (dog, cat, skunk, etc.); the circumstances of the bite; and information on the particular animal involved, if known (name of owner, etc.). In some cases, it is important to notify the animal control or other authorities so that the appropriate action can be taken.
Diagnosis	Not applicable.
Mode of Transmission	The animal bite may result in a wound which can be contaminated by bacteria or viruses in the animal's mouth and saliva.
Incubation Period	Varies according to the specific disease involved.
Infectious Period	Not relevant.
Management of Contacts	Not applicable.
Other School Children	Not applicable.
Management of Cases	First aid for an animal bite is important and will reduce the risk of any type of infection, including rabies. Wash the wound thoroughly with soap and water, and rinse well -- keep washing for up to 10 minutes. Then, the child should be seen by a physician or consultation with a physician should be obtained. The physician will evaluate the need for antibacterial, anti-tetanus, and anti-rabies treatments. Information on the type of animal and circumstances is essential for the physician in order to make these decisions.
Adults	Not relevant.
Preventive Measures	Animal control regulations can prevent many animal bites. Most animal bites are from dogs and cats.
Public Health Importance	The Epidemiology Office can assist the physician in evaluating the need for anti-rabies treatment. In addition, data on animal bites is important to assess the possible need for animal control measures.



Name of Disease	**CHICKEN POX**
Infectious Agent	The varicella-zoster virus.
Clinical Description	The first symptoms (prodome) include fever and malaise; however, in children the fever and malaise often appear at the same time as the rash. The rash (see figure) develops in successive crops, and is most significant on the trunk, although the extremities and head are also involved. The rash lesions rapidly progress from a small spot to a blister-like lesion, and then to a crusted lesion. The scabbed lesions may last for 5-20 days, but do not leave scars.
Diagnosis	Diagnosis may be rapidly made by microscopic examination of material obtained from the blister stage lesions. Testing by serology is also available. Usually, the clinical diagnosis is specific and accurate.
Mode of Transmission	Direct person-to-person, by direct contact, and also possibly via airborne route. Chicken pox is highly contagious.
Incubation Period	10-21 days; usually about 2 weeks.
Infectious Period	From about 1-3 days before the rash appears until all lesions have become crusted over.
Management of Contacts	Surveillance.
Other School Children	Surveillance.
Management of Cases	A case of chicken pox should be excluded from school until all lesions have become crusted over, since at that time they are no longer infectious.
Adults	Surveillance.
Preventive Measures	No vaccine is available against chicken pox. Persons with depressed immunity (immuno-suppressed) should be referred to their private physician since they may be at risk of developing a severe form of the disease.
Public Health Importance	Notify the Epidemiology Office when outbreaks occur. Individual cases do not need to be reported.

Name of Disease	**COMMON COLD**
Infectious Agent	The common cold is caused by many different viruses (rhinovirus, adenovirus, etc.).
Clinical Description	The common cold needs no description. The "upper respiratory infection" refers to infections of the respiratory tract not including pneumonia.
Diagnosis	Clinical diagnosis. It is possible to make a diagnosis by isolating the virus, or by serologic means, but this is rarely needed or indicated.
Mode of Transmission	Person-to-person via respiratory secretions (saliva, mucous, sneezing, coughing) and rubbing eyes or contact with mucous membranes.
Incubation Period	The common cold: 1-3 days; various upper respiratory infections range from several days to more than one week.
Infectious Period	The common cold is most infectious at the onset of illness, and much less infectious after several days of symptoms.
Management of Contacts	Since a person with the common cold is most infectious at the very onset of illness, it is very likely that a school child with the common cold has already infected other children by the time the diagnosis is made.
Other School Children	See above.
Management of Cases	For the reasons mentioned above, exclusion of a child with a common cold may not help to reduce the spread of illness significantly. Therefore, it may be reasonable to permit a child with a common cold to remain in school, unless symptoms become severe and the child requires home care.
Preventive Measures	Although many "home remedies" exist to prevent colds, there are no preventive measures of proven efficacy available at this time.
Public Health Importance	Not necessary to report unless widespread school absenteeism has occurred -- this may be indicative of influenza in the community.

Name of Disease	**CONJUNCTIVITIS, ACUTE (PINKEYE)**
Infectious Agent	There are many causes of acute conjuntivitis that are noninfectious, such as allergies. Among the list of infectious causes are viruses, chlamydia, parasites, fungi, and numerous bacteria including streptococcus pneumoniae, haemophilis species, staphylococcus aureus, and Neisseria gonorrhoeae.
Clinical Description	Acute conjunctivitis causes an intensely red eye associated with a scratchy sensation; there is often an exudate that may cause the eyelids to stick together or cause visual blurring. There is usually minimal photophobia. There are variations associated with different etiologic agents.
Diagnosis	Diagnosis depends upon careful history, physical exam, and laboratory examination. Treatment of the individual and prevention of secondary cases depend on an accurate, specific diagnosis.
Incubation Period	The incubation period varies according to the cause of the eye inflammation. It is usually 24 to 72 hours with acute bacterial conjunctivitis.
Infectious Period	The infectious period also varies according to the cause of the inflammation. In cases of bacterial conjunctivitis a person is infectious during the active stage of disease.
Management of Contacts	This, too, depends on the cause of the inflammation. Children under 5 years of age and debilitated persons are most susceptible to acute bacterial conjuntivitis.
Management of Cases	This depends on the specific cause of the inflammation. Children should not attend school during the acute stage if they have bacterial conjuntivitis.
Adults	Same as children.
Preventive Measures	Good personal hygiene, hygienic care and treatment of affected eyes, and disinfection of articles soiled with discharges are the most important preventive measures.
Public Health Importance	In recent years, outbreaks of acute conjunctivitis have been related to swimming pools; in these outbreaks, the infectious agents have been certain parasites and viruses.

Name of Disease	**CYTOMEGALOVIRUS INFECTIONS**
Infectious Agent	Cytomegalovirus (CMV)
Clinical Description	The most severe form of the disease is congenital infection. This may be manifest as jaundice, enlargement of the liver, skin lesions, infections of the eye or brain. Survivors may have microcephaly, mental retardation, and hearing loss. About 1% of children are infected with the virus at birth, but severe congenital infection only occurs rarely. Most children infected at birth remain asymptomatic, although 10% may eventually demonstrate some degree of neurosensory disability. Preschool children are often infected, especially in day-care situations. Most preschool children have no symptoms when infected. Older children and adults may have a disease which resembles infectious mononucleosis with swollen glands and fatigue.
Diagnosis	The diagnosis is confirmed by isolation of the virus from bodily fluids in viral culture.
Mode of Transmission	The virus is excreted in urine, saliva, breast milk, cervical secretions and semen. The disease is probably spread most often by contact with saliva containing the virus. It may also be spread by sexual contact. CMV may be spread from mother to baby in the uterus, during the birthing process, or during breast feeding.
Incubation Period	Generally 3 to 12 weeks after exposure.
Infectious Period	The virus is excreted in urine or saliva for many months and may persist or be excreted episodically for 5 to 6 years following a primary infection. In adults, the virus is excreted for a shorter period of time, but the virus may persist as a latent infection.
Management of Contacts	Since infection is almost universal, only surveillance is indicated.
Management of Cases	Since infection with CMV is almost universal, children who are known to be excreting should not be excluded from school.
Adults	Most adults are immune. Women who are pregnant or trying to become pregnant may wish to consult their obstetrician to learn if they are already immune. However, immunity in the mother does not confer absolute protection against CMV and congenital infection may result from reactivation of maternal infection.
Preventive Measures	Women who are of childbearing age and work with preschool or mentally retarded children should observe strict hygienic measures with a strong emphasis on hand-washing.
Public Health Importance	Infection is almost universal and no vaccine is available at the present time.

Name of Disease	**DIPHTHERIA**
Infectious Agent	C. diphtheriae (bacteria)
Clinical Description	Diphtheria can involve the throat, nose, larynx, or skin. Symptoms include fever, sore throat, weakness. Typically, grey patches appear on the affected area (tonsils, back of throat). Severe swelling of the neck and difficulty breathing may appear in severe cases. Diphtheria of the skin may resemble impetigo or other bacterial skin lesions.
Diagnosis	The diagnosis of diphtheria is both clinical and bacteriologic. Laboratory diagnosis involves culture of the grey patches in an attempt to isolate the C. diphtheriae organisms. Clinical diagnosis may be difficult.
Mode of Transmission	Person-to-person, through contact with secretions of a case or healthy carrier. Skin diphtheria can be transmitted by contact with infected skin lesions. Materials contaminated with respiratory secretions can also transmit disease.
Incubation Period	Usually 2-6 days, occasionally longer.
Infectious Period	Usually 2-4 weeks in untreated cases, but as short as 2-4 days in cases treated with antibiotics. Healthy carriers can also transmit the disease.
Management of Contacts	A case of diphtheria in the school setting is not likely to result in illness in other school children. However, children should be cultured, examined for suspicious skin lesions, immunized if a booster is indicated, and placed under surveillance so that cases of possible disease will be quickly identified and referred to a physician.
Management of Cases	A case of diphtheria requires immediate evaluation and treatment by a physician. When the patient has recovered from the illness, as determined by the physician, he/she may return to school.
Adults	In most cases, a booster inoculation with tetanus-diphtheria vaccine is indicated, as well as a throat culture.
Preventive Measures	Immunization with diphtheria toxoid (in both DPT and Td series) provides protection against the severe systemic effects of diphtheria toxin.
Public Health Importance	Cases must be reported immediately. The Epidemiology Office will assist private physicians and also organize community disease control measures.

Name of Disease	**FIFTH DISEASE** (Erythema Infectiosum)
Infectious Agent	Human parovirus
Clinical Description	Fifth disease is characterized by a mild, usually nonfebrile eruption characterized by a striking erythema of the cheeks (slapped-face appearance) and reddening of the skin which fades and recurs. The body may show a lacelike rash, exaggerated by exposure to heat or sunlight. Fifth disease usually occurs in outbreaks among school age children.
Diagnosis	Characteristic clinical appearance occurring in epidemic manner. Laboratory tests available only in research laboratories.
Mode of Transmission	Probably via respiratory route or through contact with infected saliva.
Incubation Period	Unknown but apparently 6 to 14 days.
Infectious Period	Unknown.
Management of Contacts	Surveillance.
Management of Cases	The illness is usually mild. No treatment is indicated. Since many infections are asymptomatic, excluding children with fifth disease from school serves no useful purpose.
Preventive Measures	None.
Public Health Importance	At the beginning of an outbreak, fifth disease must be distinguished from rubella.

Name of Disease	**GIARDIASIS**
Infectious Agent	*Giardia Lamblia* (a protozoan)
Clinical Description	Giardiasis is an intestinal infection. The major clinical manifestations include diarrhea, weight loss, and loss of appetite. The diarrhea of giardiasis is often chronic, lasting for weeks or months. Some persons may carry the giardia and be without symptoms (asymptomatic carriers).
Diagnosis	Diagnosis is established by identification of the *Giardia lamblia* in the stool.
Mode of Transmission	Person-to-person via water contamination with *Giardia lamblia* cysts. Spread via the fecal-oral route may also occur, and may be the major form of spread in preschool settings.
Incubation Period	Extremely variable, probably from 1 to 4 weeks.
Infectious Period	Variable. An untreated case may continue to excrete giardia cysts in the stool for very long periods of time.
Management of Contacts	Sanitary precautions, surveillance.
Other School Children	Sanitary precautions, surveillance. In some settings, stool surveys may be indicated in order to detect asymptomatic carriers.
Management of Cases	As long as sanitation is adequate, there is no reason to exclude a child with giardiasis from the school. However, untreated or inadequately treated giardiasis may result in symptoms including frequent diarrheal bowel movements -- sanitary precautions may be necessary to prevent spread. In the preschool setting there is an increased risk of person-to-person transmission.
Adults	Hygiene.
Preventive Measures	Hygiene.
Public Health Importance	Cases of giardiasis may result from a contaminated water supply. In order to exclude this possibility, notify the Epidemiology Office. In some cases, stool surveys within a school may be indicated.

Name of Disease	GONORRHEA
Infectious Agent	Neisseria gonorrheae (bacteria)
Clinical Description	Gonorrhea may be a symptomatic or an asymptomatic illness. Symptomatic illness involves the inflammation of the genitourinary tract, with symptoms of burning on urination and a penile discharge (male) or vaginal infection (female). Other sites, including rectum and throat, may also be infected. It is essential to obtain a culture for diagnosis in any suspected case of gonorrhea -- the diagnosis cannot be made on symptoms alone.
Diagnosis	Laboratory culture of the causative organism, Neisseria gonorrheae.
Mode of Transmission	Transmitted almost exclusively by sexual contact. Infection by contact with fomites (inanimate objects, including toilet seats) rarely if ever occurs.
Incubation Period	Ranges from 1-14 days, but is usually from 3 to 5 days.
Infectious Period	In untreated cases, the organism may be transmitted for long periods (carrier). Once treated with antibiotics, the infectious period is almost immediately terminated.
Management of Contacts	Only sexual contacts are at significant risk of infection.
Management of Cases	There is no reason to exclude school children with gonorrhea from class. However, a complex situation, requiring individual evaluation, obviously exists.
Adults	Only sexual contacts are at risk of infection.
Preventive Measures	Treatment of cases and tracing of sexual contacts are essential to prevent further transmission of the disease.
Public Health Importance	Depending upon the age of the infected person, a complex medical and legal situation may be involved. Cases of gonorrhea in minors represent potential instances of child abuse and notification of appropriate authorities (Social Services Division, Human Services Department) may be indicated.

Disease	**HEPATITIS, INFECTIOUS**
Infectious Agent	Hepatitis A virus
Clinical Description	Hepatitis A can be expressed in two major forms. The classic form is with jaundice: following about one week of nonspecific, often gastrointestinal complaints (nausea, vomiting, loss of appetite), yellow jaundice will appear. The second form, which is actually more common in children, involves the nonspecific and gastrointestinal complaints but the jaundice is absent. For this reason, most cases of hepatitis are probably not recognized.
Diagnosis	A specific diagnosis is based on the finding of Igm antibodies to the Hepatitis A virus in the blood. Laboratory tests of liver function reveal evidence of moderate liver abnormality during illness.
Mode of Transmission	Fecal-oral, foodborne, waterborne. Virus is excreted in the stools of infected persons and can spread when sanitary conditions are inadequate. Virus contaminating food or water leads to outbreaks of hepatitis.
Incubation Period	Ranges from 15-50 days, usually 25 to 30 days.
Infectious Period	A person with hepatitis A is most infectious just before the onset of jaundice. Communicable from 1-2 weeks before until 1 week after onset of jaundice.
Management of Contacts	Preschool children are most likely to spread illness since their hygienic measures are often inadequate. However, older school children (above preschool) are unlikely to spread hepatitis A within the classroom. While administration of gamma globulin (ISG) is not generally recommended for all school contacts of cases of hepatitis A, it will be indicated in some circumstances.
Management of Cases	Many cases of hepatitis A in school children will pass unnoticed since without jaundice it is difficult to diagnose clinically. If a child feels well enough to be in school, and if basic sanitary precautions can be respected (i.e., hand-washing after defecation), a child with hepatitis A can remain in school. A preschool child with hepatitis A should probably remain out-of-school until at least 1 week after the start of jaundice.
Adults	Adults tend to have more severe cases of hepatitis A, with more complications than children. Adults in contact with cases of hepatitis A should receive ISG.
Preventive Measures	Ill and jaundiced persons should not be working at food measures. Good hygiene will prevent person-to-person spread.
Public Health Importance	Investigation for a possible common source (i.e., food or water) exposure is indicated. Consult with the Epidemiology Office on need for ISG administration (how much and for whom) and community tracing of contacts in need of ISG.

Name of Disease	**HERPES INFECTION, GENITAL**
Infectious Agent	Mostly Herpes Simplex Virus, type 2.
Clinical Description	The clinical picture is similar to that of acute herpes infection of the mucous membranes of the mouth. The perineal area is usually reddened, edematous, and studded with shallow white ulcers 2 to 4 mm. in diameter. The ulcers may coalesce to form large ulcers. The ulcers are very painful. In addition, the inguinal lymph nodes are enlarged and tender; the patient may have fever and weakness lasting 5 to 7 days. The ulcers usually heal completely, without scarring, in 3 weeks. Recurrent infections occur frequently but are not associated with fever and constitutional symptoms.
Diagnosis	
Mode of Transmission	Genital herpes is almost always spread by some form of sexual contact.
Incubation Period	Up to 2 weeks.
Infectious Period	Greatest early in the course of infection; many asymptomatic persons shed the virus intermittently.
Management of Contacts	Education. Children with eczema and newborn infants must be protected from exposure to persons with active herpes infections.
Management of Cases	Isolate the case from the contacts listed above. Smallpox vaccination is not an effective therapeutic measure and is dangerous because of the potential complications of the vaccine.
Adults	Persons of all ages may be susceptible.
Preventive Measures	Genital herpes infection in late pregnancy is serious because the risk of neonatal herpes which may be fatal. Pregnancy status of all females should be determined so that appropriate measures may be taken at the time of delivery.
Public Health Importance	Individual cases are of minor public health significance.

Disease Name	**HERPES SIMPLEX**
Infect. Agent	Herpes simplex virus (HSV), types I and II
Clinical Description	Most children are infected early in childhood with HSV-1. Only about 10% of infections are symptomatic. Symptoms of HSV infections are blisters on the skin and/or mucus membranes, most commonly the mouth for HSV-I infections and the genitals for HSV-II infections. The virus may also spread to the eye and cause keratoconjunctivitis. Rarely the virus may cause encephalitis, pneumonia, or spread throughout the entire body. These more serious infections usually occur in newborns or persons with underlying immune problems. Both HSV-I and HSV-II may produce recurrent infections, in which the patient has repeated episodes of the disease initiated by trauma, emotional stress, illness, or fever.
Diagnosis	The diagnosis is made on the physical appearance of the lesions, which are initially manifest as blisters that crust and heal within a few days. Viral cultures may be necessary for the diagnosis of unusual forms of the disease.
Mode of Transmission	Contact with saliva of carriers of the virus is probably the most important mode of spread for HSV-I. The carrier need not have active lesions to spread the virus. Skin to skin contact may result in spread among wrestlers. Sexual contact is the most important means of spread for HSV-II. Spread of the virus from the genital tract of an infected woman to her baby during the birth process may result in a serious infection of the newborn.
Incubation	Two to 12 days for primary infection.
Infectious Period	The virus may be found in saliva for up to 7 weeks after a primary infection. Patients with genital herpes are infective for 7 to 12 days following onset of a primary infection and for up to a week after a recurrent infection. About 50% of patients with genital herpes will have recurrent infections. Patients with either oral or genital herpes that is recurrent may have asymptomatic shedding of the virus and may be capable of spreading the infection when they have no symptoms.
Management of Contacts	Education. Children with eczema and newborns must be protected from exposure to persons with active herpes infections. Since most children are already infected with oral herpes, only surveillance is recommended. Genital herpes infection will not be spread under ordinary circumstances within the school environment. Spread via toilets is unlikely.
Management of Cases	Refer to a physician for severe primary infection. No therapy is warranted for recurrent oral lesions. Genital herpes in a school child may be indicative of sexual abuse.
Adults	Surveillance.
Preventive Measures	Sexually active persons may reduce their risk of acquiring genital herpes by using condoms.
Public Health Importance	Herpes is a common and minor infection. If genital herpes occurs in a school child and sexual abuse is suspected, appropriate authorities should be notified.

Name of Disease	IMPETIGO
Infectious Agent	Streptococcus (bacteria)
Clinical Description	Impetigo is an infection of the skin. Pustules, vesticles (little blister-like lesions), and crusted areas are most common. Impetigo is generally a disease of late summer and early fall, although it occurs year-round. Younger children are commonly infected. Treatment is important to help prevent late complications of streptococcal skin infection.
Diagnosis	Although an impetigo-like lesion may be caused by other types of bacteria, the classic appearance of the disease, with its "honey colored" crusting often establishes the diagnosis. The lesions may be cultured in order to confirm the diagnosis.
Mode of Transmission	Direct person-to-person contact between children is the most common mode of transmission.
Incubation Period	2-5 days.
Infectious Period	Unknown; the case of impetigo treated with antibiotics should become noninfectious earlier; noncontagious when lesions are healed.
Management of Contacts	Careful observation of contacts and persons living in close contact (home and school). If lesions of impetigo appear, refer infected contact for treatment.
Other School Children	
Management of Cases	Combination of careful cleaning of the lesions and antibiotic therapy. It may be reasonable to exclude a child with impetigo until 24 hours after antibiotic treatment has been started.
Adults	
Preventive Measures	Hygiene.
Public Health Importance	Cases of impetigo may be associated with development of acute glomerulonephritis (kidney disease). Cases of glomerulonephritis associated with impetigo should be reported, so that community investigation can be carried out to prevent further cases of glomerulonephritis.

Name of Disease	**INFECTIOUS MONONUCLEOSIS**
Infectious Agent	Epstein-Barr virus (EB virus)
Clinical Description	Persons with "mono" usually have fever, severe sore throat, weakness, and enlargement of lymph nodes. Jaundice may occur, but it is uncommon.
Diagnosis	The diagnosis is made by history, physical examination, and the typical laboratory findings in the blood. The major characteristic of blood of a patient with "mono" is the increase in lymphocytes, with many so-called "atypical lymphocytes."
Mode of Transmission	Transmission probably occurs from person-to-person via contact with respiratory secretions. The disease may also be transmitted by blood transfusion. Infectious mononucleosis is probably not highly contagious.
Incubation Period	2 to 6 weeks.
Infectious Period	Unknown.
Management of Contacts	Surveillance.
Other School Children	Surveillance.
Management of Cases	There is no specific treatment for "mono." In addition, there has never been a documented outbreak or epidemic of "mono." Therefore, while the ill child may wish to remain at home (fatigue may be severe and last for months), there is no reason to exclude a child with mono from school.
Adults	Surveillance.
Preventive Measures	None.
Public Health Importance	Sporadic cases of infectious mononucleosis are not important. If more than one case is involved, notify the Epidemiology Office.

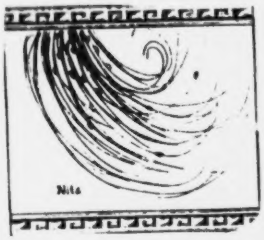
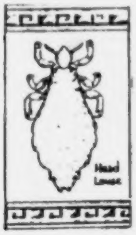
Name of Disease	**INFLUENZA**
Infectious Agent	Influenza virus (types A and B)
Clinical Description	Influenza virus causes an acute infection characterized by fever, headache, malaise, sore/scratchy throat, cough, and muscle aches. It is often not distinguishable from other upper respiratory infections caused by viruses.
Diagnosis	Since influenza is one of the only diseases which causes widespread and community-wide illness, the clinical diagnosis is relatively straightforward when an outbreak of influenza occurs. Laboratory diagnosis by isolation of the virus from throat swabs is possible, and infection can also be documented by serology.
Mode of Transmission	Person-to-person through respiratory droplets from the nose and throat.
Incubation Period	1 to 3 days.
Infectious Period	Persons with flu are most infectious just before the onset of their symptoms. The infectious period ends about 3 days after the start of illness.
Management of Contacts	Isolation is not indicated. Once an outbreak of influenza has started, immunization is of little or no value, since protection levels of antibody do not develop until 10-14 days after vaccination.
Management of Cases	When a case of influenza is diagnosed in a school, the virus has already had sufficient time to spread throughout the school population. For this reason, isolation or exclusion from school is not really necessary. However, children ill with acute influenza probably require good home-care.
Adults	Same as "Management of Contacts," above.
Preventive Measures	Influenza vaccines are useful only if given well before the flu epidemic begins. Children who belong to high risk groups (severe heart or lung disease, metabolic disease, cancer, immune deficiency diseases) should be vaccinated every fall. A drug, Amantadine, is also available to prevent disease for some individuals during outbreaks.
Public Health Importance	When influenza strikes a community, it often starts in the school-aged population. Notify the Epidemiology Office if an apparent influenza outbreak is present, since this establishes the presence of influenza in the community.

Name of Disease	**MEASLES** (Rubeola)
Infectious Agent	Measles virus.
Clinical Description	The first symptoms (the prodrome) consist of fever, cough, red and watery eyes, and coryza (head cold symptoms). After 2-4 days of prodromal illness, the rash appears first on the face, then spreads to the trunk and legs. The rash lasts 4-7 days. Complications of measles infection include inflammation of the brain, middle ear infections, pneumonia, and death. The patient with measles usually appears quite ill.
Diagnosis	The clinical appearance is usually classic. Measles virus can be isolated from the patient, but laboratory testing usually involves serology.
Mode of Transmission	Person-to-person. The most common route of transmission is via respiratory droplets. Measles is extremely infectious.
Incubation Period	Usually 10-14 days.
Infectious Period	From approximately 7 days before until 7 days after the rash appears.
Management of Contacts	Immunization of previously unimmunized persons should be considered since it may prevent the disease, even in persons already exposed to the disease. In some cases, use of large doses of ISG (gamma globulin) may prevent the disease. Surveillance of new cases is vital to halt further spread of the disease.
Management of Cases	A case of measles should be excluded from school until 7 days after the start of the rash. However, it must be recognized that at the time the rash first appears, the patient has already been highly infectious for as long as 7 days.
Adults	Most adults had measles infection during childhood, and immunization is rarely indicated.
Preventive Measures	Live measles virus vaccine is over 90% effective in preventing measles infection. Use of the vaccine can control measles, a disease which used to be an important cause of childhood-onset retardation and death.
Public Health Importance	Measles spreads rapidly and occurs in epidemics. It is essential to report cases of measles promptly. If it is indeed measles, a control measure to limit the spread of the disease in the community will be conducted by the Health and Environment Department.

Measles
1st day of rash
3rd day of rash
rash discrete
confluent maculopapular
discrete maculopapular

Name of Disease	**MENINGOCOCCAL MENINGITIS**
Infectious Agent	Neisseria meningitidis (bacteria)
Clinical Description	Meningococcal meningitis is severe and life threatening. Meningitis is characterized by high fever, stiff neck, headache, vomiting, and possibly stupor or loss of consciousness. Meningococcal infection may also be accompanied by a purple colored rash. Many people carry the bacteria Neisseria meningitidis in their throats and never develop any symptoms or disease (these are asymptomatic carriers).
Diagnosis	The constellation of signs and symptoms may lead to a presumptive diagnosis. However, laboratory work, including isolation of Neisseria meningitidis from spinal fluid or blood, is needed to confirm the diagnosis.
Mode of Transmission	Person-to-person through droplet spread or contact with respiratory secretions. Carriers of Neisseria meningitidis exist (see above).
Incubation Period	Ranges from 2-10 days, but is usually 3-5 days.
Infectious Period	Healthy carriers are potentially infectious. Cases of meningococcal meningitis, once started on antibiotics, are generally noninfectious within 24 hours.
Management of Contacts	Preschool children in the same class as a case of meningococcal meningitis may be at increased risk of contracting the disease. Preschool children should, therefore, be evaluated for administration of protective medication. It is generally agreed that older school children, even if in the same class room as a case of meningococcal meningitis, are not at increased risk of contracting the disease. Extremely close, prolonged, person-to-person contact seems necessary in order to transmit the disease from an ill person to a healthy contact. It is important to start surveillance so that suspect ill children are immediately evaluated by a physician.
Management of Cases	This is a life-threatening illness requiring hospitalization. When the child has recovered, he/she may return to school without limitation.
Adults	Similar considerations apply as under "Management of Contacts."
Preventive Measures	When a case has been diagnosed, preventive measures are needed only in certain circumstances.
Public Health Importance	It is essential that cases of meningococcal meningitis be reported immediately to the Epidemiology Office so that an evaluation of who should or should not receive protective medication can be made.

Name of Disease	**MUMPS**
Infectious Agent	Mumps virus
Clinical Description	Mumps is a systemic disease, affecting many organ systems. However, the most common form is characterized by fever and swelling of the salivary glands. The parotid gland, located behind the angle of the jaw and just below the ear, is often swollen and tender.
Diagnosis	While virus isolation and serology are possible, the diagnosis is virtually always established on clinical grounds.
Mode of Transmission	Mumps virus is present in saliva. Mumps is spread by respiratory droplets or other contact with respiratory secretions.
Incubation Period	12-26 days; average is 18 days.
Infectious Period	From 7 days before swelling begins until about 9 days after swelling begins. Subclinical cases of mumps are also infectious.
Management of Contacts	Immunization of contacts of mumps cases who are unimmunized and who have no history of previous mumps infection can be considered. However, it is unclear whether further cases of mumps can be prevented in this manner (i.e., once the exposure to mumps virus has occurred).
Other School Children	
Management of Cases	The patient with mumps should be excluded from school from the time of diagnosis until the swelling has disappeared (about 7-10 days in most cases).
Adults	Adults with no prior history of mumps illness should be considered for mumps vaccine.
Preventive Measures	Mumps vaccine.
Public Health Importance	Individual cases are of minor public health significance.

Name of Disease	PEDICULOSIS
Infectious Agent	Pediculus humanus capitus, the head louse, a blood sucking insect.
Clinical Description  	The major symptom of head louse infection is itching on the nape of the neck and behind the ears. Scratching may lead to a secondary bacterial infection in these areas.
Diagnosis	Diagnosis is made by seeing and identifying either the crawling forms or the eggs/egg casings (nits). Most persons with head lice infestations will have only between 10 and 20 lice.
Mode of Transmission	Lice can be transmitted by close personal contact, but are more frequently transferred on objects such as hats, coats, brushes.
Incubation Period	Infestation begins once the lice are present.
Infectious Period	The person with head lice is infectious while adult lice are present.
Management of Contacts	Simple examination will determine if other school children are infested. Surveillance for new cases is important. When one case of head lice is found in a school room, examination of all other students is appropriate.
Management of Cases  	A child with head lice should be excluded from school until he/she has been given the first treatment with specific anti-lice medication. Clothing worn by the child must be laundered and other personal objects must be treated. Children should be allowed to return to school only after presenting some proof that the anti-lice treatment has been given. The child may be given a second treatment 10 days after the first treatment; however, the child is not infectious after the first treatment has been given.
Adults	Same as for "Management of Contacts."
Preventive Measures	Arrange for storage of personal clothing such as coats, hats, and scarves in separated containers or on hooks widely separated so that one child's articles are not in contact with any other child's articles.
Public Health Importance	The Epidemiology Office can help with details of treatment and methods for de-lousing of personal objects. Head lice are not a serious threat to health, but rather a "nuisance" phenomenon. In addition, there is no real correlation between a child's sanitary state and the risk of contracting head lice (i.e., a child is not considered "dirty" because he/she gets head lice).

Name of Disease	**PERTUSSIS**
Infectious Agent	Bordetella portussis (bacteria)
Clinical Description	Whooping cough has three stages: the catarrhal phase (runny nose, mild cough) which lasts 1-2 weeks; the paroxysmal phase (typical severe whooping cough) lasting up to 8 weeks; and the convalescent phase (recovery). The disease is of variable severity, with mild cases closely resembling other "cough" infections (usually viral). Pertussis is especially severe in very young children.
Diagnosis	Early in the illness, the bacteria can be cultured or stained with a fluorescent antibody method (rapid diagnosis). Later in the illness, the bacteria are no longer present and the diagnosis must rely on the clinical picture.
Mode of Transmission	Person-to-person via respiratory route.
Incubation Period	Usually 7-10 days.
Infectious Period	Most infectious during the catarrhal phase. If treated with antibiotics, the patient becomes non-infectious within days; if untreated the patient remains infectious for 2-3 weeks.
Management of Contacts	Fully-immunized children should be placed under surveillance only. Partially or unimmunized children should be given DPT injections (if under 6 years of age) and may be considered for protective administration of erythromycin (antibiotic). Partially immunized and unimmunized children 6 years of age and older should be considered for protective erythromycin. Careful surveillance is indicated.
Management of Cases	Cases of pertussis should be excluded from school. Cases should be treated with erythromycin as soon as possible to reduce the risk of further spread of the disease. Cases may return to school one week after starting erythromycin treatment, or 3 weeks after the onset of the cough in cases not treated with erythromycin.
Adults	Adults in contact with pertussis should be placed under surveillance. Consider preventive administration of erythromycin.
Preventive Measures	Immunization with DPT vaccine for children less that 6 years of age.
Public Health Importance	It is essential to notify the Epidemiology Office of cases of pertussis. The State Health Agency will direct community-wide disease control activities and will consult on the need for preventive medication.

Name of Disease	**PLAGUE**
Infectious Agent	Yersinia Pestis
Clinical Description	Most patients have bubonic plague with high fever, malaise, and a swollen, very tender lymph gland in the groin, armpit or neck. A minority of patients have septicemic plague manifested only by high fever and malaise. Pneumonic plague may occur late in the illness with cough and the production of bloody sputum. Other symptoms such as headache, muscle aches, vomiting, diarrhea, and abdominal pain are variably present.
Diagnosis	Isolation of Y. pestis from culture material, usually blood or material aspirated from a lymph node. Rapid and presumptive diagnosis may be made by a fluorescent antibody test performed on material aspirated from a lymph node.
Mode of Transmission	Plague is a disease of rodents and fleas in nature. Humans are infected rarely by one of three means. 1) They may be bitten by a plague infected flea. They may come into contact with fleas by traveling into areas where there has been plague in the rodent population and inflected fleas jump onto the person seeking a blood meal. Infected fleas may also be brought into the home by pet dogs or cats. 2) They may be bitten by a carnivore (usually a pet cat) that has become infected with plague by eating plague-infected rodents. 3) They may have direct contact with the tissue of a plague-infected mammal, usually by skinning game animals.
Incubation Period	Usually 5-7 days for bubonic plague. May be as short as 1-2 days for human to human transmission of pneumonic plague.
Infectious Period	Plague is not normally spread from human to human except with pneumonic plague. The infectious period for a case of pneumonic plague is from the time the patient begins to cough until the patient has completed several days of antibiotic therapy.
Management of Contacts	Contacts of pneumonic plague cases should be given antibiotic therapy immediately. Identification of appropriate contacts is performed by the Epidemiology Office on an emergency basis.
Management of Cases	Plague is a highly fatal infection. Suspect cases should be referred to a physician promptly.
Preventive Measures	Pet dogs and cats should not be permitted to roam during the summer months. Dogs and cats that do roam should be dusted with flea powder on a weekly basis. Hunters should avoid contact with game animals that appear ill and should wear gloves when skinning game and preparing raw flesh for consumption.
Public Health Importance	The occurrence of a case of pneumonic plague is a public health emergency. Cases of plague should be reported immediately to the Epidemiology Office.

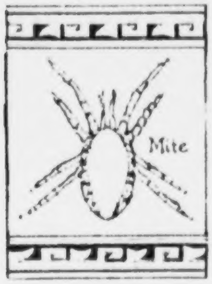
Name of Disease	**POLIO**
Infectious Agent	Polio virus
Clinical Description	In its more severe form, polio virus causes paralysis of muscles, which may also involve the muscles of respiration. However, mild polio infections are more common that the paralytic type: these may involve fever, sore throat, headache, and gastrointestinal complaints. The symptoms of mild polio are similar to symptoms of many viral diseases of little consequence. Therefore, at this time in the United States, there is no reason to consider or suspect polio unless muscle paralysis or severe weakness occurs.
Diagnosis	The clinical diagnosis may be difficult to make, as even paralytic polio may resemble other neurologic conditions. In the laboratory, the virus may be isolated from throat swabs or feces; a serologic diagnosis is also possible.
Mode of Transmission	Virus is transmitted from person-to-person through contact with either the throat secretions (saliva) or feces of a person with polio.
Incubation Period	3-21 days, but usually 7-12 days.
Infectious Period	Variable. Secretions and stools may be infectious from just prior to illness to several weeks after the onset of illness. The most communicable period is probably from several days before until 1 week after the onset of illness.
Management of Contacts	Since a case of polio is most infectious before the onset of symptoms, the virus has already had a chance to spread widely through the school population by the time a case of polio has been diagnosed. Children throughout the community should receive a booster dose of oral polio vaccine.
Management of Cases	Cases of polio must be excluded from school for at least 1 week after the onset of symptoms.
Adults	Adults may be considered for a dose of oral polio vaccine if they are contacts of a case of polio.
Preventive Measures	Currently used oral polio vaccine (TOPV) results in very high levels of protection against all three types of polio virus.
Public Health Importance	A documented case of polio is a community emergency. Notify the Epidemiology Office immediately.

Name of Disease	**RINGWORM OF THE SCALP & BODY** (Tinea capitis and Tinea corporis)
Infectious Agent	Fungi of the genera microsporum and trichophyton.
Clinical Description	Ring-shaped lesions on the head or body, usually reddish, scaly, crusted, occasionally bloody, and purulent in appearance.
Diagnosis	Diagnosis is made by microscopic examination of scrapings placed in 10% potassium hydroxide solution, culture, or positive fluorescence by Wood's light examination. These diseases must be diagnosed by a competent professional.
Mode of Transmission	Direct or indirect contact with skin and scalp lesions of infected persons or animals, especially contact with backs of seats, contaminated clothing, shower rooms, and benches.
Incubation Period	4 to 21 days.
Infectious Period	As long as fungi can be cultured or shown by Wood's light fluorescence.
Management of Contacts	Wood's light examination and, if that test is inconclusive, cultures should be taken of all potential contacts. Search for both bright green (microsporum) and dull green (trichophyton) fluorescing lesions as well as bald and well circumscribed areas, especially in children with unkempt hair.
Management of Cases	No isolation or exclusion of the student is necessary if the case is taking antifungal treatment. A cap covering the head effectively contains broken hairs and scales of scalp ringworm cases.
Adults	Household contacts and pets of the case should be examined for evidence of infections and treated if necessary.
Preventive Measures	If cases occur relatively frequently in a school, consideration should be given to routine screening of all children with Wood's light examination. In addition, body infections can be prevented by proper laundering of towels and clothing, and attention to general cleanliness in showers and dressing rooms of gymnasiums including repeated washing of benches and floors.
Public Health Importance	Ringworm is not a serious threat to health but can be a nuisance. Certain serious diseases such as psoriasis or abnormal endocrine states may be similar in appearance or cause persistence of lesions.

Rubella
1st day of rash
3rd day of rash
rash discrete

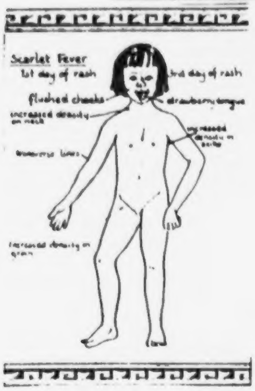
Name of Disease	**RUBELLA**
Infectious Agent	Rubella virus
Clinical Description	In children, the rash is often the first sign of illness. However, a mild prodromal illness, with low-grade fever, malaise, and headache may exist for 1-4 days before the rash appears. The rash appears first on the face but spreads rapidly over the entire body. The rash consists of small reddish-pink spots, and rarely lasts more than 3 days. Congenital rubella is characterized by microcephaly, mental retardation, cataracts, deafness, and heart defects.
Diagnosis	Up to one-half of rubella cases may be asymptomatic. The clinical picture, with rash and tender lymph nodes at the base of the skull or behind the ears, may be fairly diagnostic. However, laboratory confirmation by serology is essential to assure accurate diagnosis.
Mode of Transmission	Virus is excreted in throat and nose secretions, and transmission is probably by airborne (respiratory) and direct contact. Viral shedding in urine and stool may also be important in some cases. In congenital rubella, the fetus is infected early in pregnancy.
Incubation Period	14-21 days.
Infectious Period	From approximately 7 days before the rash starts until about 5 days after the rash starts. The infectious period may be quite variable. Cases of congenital rubella shed virus for months, or rarely years after birth.
Management of Contacts	Vaccination of nonimmunized children is generally part of disease control measures. Surveillance in order to detect new cases is important.
Management of Cases	The child with rubella has been highly infectious for up to 7 days before the illness could be diagnosed. For this reason, many persons will already have been exposed once the case is identified. Nevertheless, it may be reasonable to exclude the case until 5 days after the onset of the rash.
Adults	The prime goal is to prevent exposure to nonimmune pregnant women (including teachers) to rubella. Pregnant women should immediately contact their physician in order to discuss their immune status.
Preventive Measures	Immunization with rubella vaccine provides prolonged protection against rubella. It is especially important that female employees of school districts be vaccinated against rubella.
Public Health Importance	It is important to report rubella since the Epidemiology Office can then take steps to inform the general public and physician population about the potential risk to pregnant women.

Name of Disease	**SALMONELLOSIS**
Infectious Agent	Salmonella (bacteria)
Clinical Description	Salmonellosis is usually manifested as an acute gastroenteritis (diarrheal disease) with fever, nausea, vomiting, diarrhea, and abdominal pain. Salmonella causes one of the most common types of so-called "food poisoning." However, salmonella can also cause severe bloodborne infections.
Diagnosis	Clinical symptoms can suggest the diagnosis, but laboratory culture of the salmonella bacteria from the stools confirms the diagnosis.
Mode of Transmission	Fecal-oral, or by contamination of food or water with feces of either human or animal origin.
Incubation Period	Usually 12 to 36 hours.
Infectious Period	For the entire period during which the salmonella bacteria are present in the stool.
Management of Contacts	Preschool settings must be evaluated on an individual basis. In other settings, surveillance for other cases of diarrheal illness is indicated.
Other School Children	
Management of Cases	The patient with salmonella is often ill with an acute diarrheal disease, rendering management at school difficult. In preschool settings, person-to-person spread and its prevention are of major concern. In the preschool, keeping children with salmonella infections together may be desirable. In the school setting, once the patient is comfortable and able to return to school, there is no reason for exclusion (assure hygienic precautions).
Adults	Surveillance for diarrheal disease.
Preventive Measures	Enforcement of strict hygiene will help prevent person-to-person spread.
Public Health Importance	Identification of foodborne or waterborne outbreaks is possible only if cases of salmonella are reported. The Epidemiology Office will assist in the design of control measures in preschool settings.

Name of Disease	**SCABIES**
Infectious Agent	Sarcoptes scabeii, the itch mite
Clinical Description  	The major symptoms of scabies is intense itching, which is usually worse at night. Sensitization to the itch mite can also result in skin lesions which may become sites for secondary bacterial infection. Scabies itching characteristically occurs between the fingers, on the wrists, elbows, in the armpits, at the waistline, ankles, feet, and buttocks. Scabies generally spares the head, except in infants.
Diagnosis	Diagnosis is made by finding the burrows (nests) of the itch mite, where the mite has burrowed beneath the skin. A classical clinical picture is often treated with the need for scraping the burrow and examining the scrapings under the microscope.
Mode of Transmission	Person-to-person, by direct skin contact, although bedding and clothing may play a role. Transmission is usually minimal in the school setting since prolonged and intimate contact (as in families) is usually required to spread the infestation.
Incubation Period	Symptoms may not appear for as long as 4 to 6 weeks after the infestation begins.
Infectious Period	Communicable until the mites and eggs are destroyed by specific treatment.
Management of Contacts	Since scabies rarely spreads within schools, only surveillance for further cases is needed.
Other School Children	
Management of Cases	Cases do not need to be excluded from school, but must be treated since the itching will be distracting to both patient and schoolmates.
Adults	Surveillance.
Preventive Measures	None.
Public Health Importance	Families of cases of scabies must be treated, as the family unit is the major crucible for transmission of the infestation. The Epidemiology Office is available to consult on treatment and other measures.

Name of Disease	**SHIGELLA**
Infectious Agent	Shigella (bacteria)
Clinical Description	Shigella causes an acute, but usually self-limited gastroenteritis, characterized by fever, diarrhea (may be bloody), abdominal cramps, and vomiting. The diarrhea and abdominal pain of shigella may be quite severe.
Diagnosis	Shigella may be suspected on the basis of the clinical picture, but the diagnosis is confirmed by laboratory culture of the shigella bacteria from the stools.
Mode of Transmission	Fecal-oral. Shigella may also cause foodborne or waterborne outbreaks, but person-to-person spread is more important. Shigella is extremely contagious.
Incubation Period	Usually 1 to 4 days.
Infectious Period	The entire time during which shigella are excreted in the stools. Antibiotic treatment shortens the period of shigella excretion.
Management of Contacts	In the preschool setting, the potential for person-to-person spread is high and control measures must be designed on an individual basis. In the school setting, surveillance for additional cases (possibly suggestive of a common source exposure, as to contaminated food or water, or possibly due to fecal-oral transmission within the classroom) is indicated.
Management of Cases	The patient with shigella is usually miserable and requires home management. In the preschool, children with shigella should be documented (by stool culture) to be free of the organism before returning to the preschool setting. In the school, once the patient is comfortable and ceases to have diarrhea, they may return to school, with careful attention to hygiene (i.e., washing hands after defecation, no participation in any food handling or snack preparation).
Adults	Surveillance.
Preventive Measures	Strict enforcement of hygiene. No vaccine is available.
Public Health Importance	The Epidemiology Office will assist in the design of control measures appropriate for preschool settings. It is important to notify the Epidemiology Office so that food or water contamination can be excluded.

Name of Disease	**STREP THROAT/SCARLET FEVER**
Infectious Agent	Streptococcus (bacteria): a particular sub-type of the streptococcus, called Group A, beta-hemolytic strep.
Clinical Description	Classic strep throat is characterized by sore throat, fever, tender lymph glands in the neck, and a pus-like exudate on the tonsils. However, strep throat can occur without the tonsillar exudate and with minimal symptoms. Scarlet fever almost always involves the combination of strep throat plus the rash. Scarlet fever produces a fine rash, prominent in skin creases and folds, which often spreads over the entire body. As the rash fades, peeling of the skin (desquamation) is characteristic. The so-called "strawberry tongue" is also noted.
Diagnosis	A throat culture is necessary for the diagnosis of strep throat.
Mode of Transmission	Person-to-person via respiratory secretions and saliva. Outbreaks of strep throat may occur from food or milk contamination.
Incubation Period	2 to 5 days.
Infectious Period	In untreated cases, shedding of the bacteria for weeks. Shedding usually ceases within 24 hours after penicillin treatment is started.
Management of Contacts	For sporadic cases, surveillance is adequate. If many cases occur, the control approach must be individualized.
Other School Children	
Management of Cases	Exclude from school until clinical recovery and treatment has started.
Adults	Surveillance.
Preventive Measures	None. It is important to treat streptococcal infections in order to prevent the later development of rheumatic fever.
Public Health Importance	Notify the Epidemiology Office if many cases are occurring, which points to the need for systematic outbreak control and evaluation of possible common source (food, milk) exposures.



Name of Disease	**SYPHILIS**
Infectious Agent	Treponema pallidum (a spirochete type bacteria)
Clinical Description	Syphilis may take many forms. It can be an acute and chronic infection characterized by a primary lesion at the initial site of infection 3 weeks after exposure; the lesion begins as a papule that may undergo erosion to a distinctive indurated chancre. The chancre disappears even without specific treatment. However, infection without chancre is frequent. Secondary syphilis is characterized by eruptions involving skin and mucous membranes, usually occurring 6 to 9 weeks after infection. The secondary manifestations may disappear spontaneously in weeks to months with subsequent clinical latency for weeks to years. Late manifestations may cause death or disabling effects in the skin, bone, viscera, cardiovascular and central nervous systems.
Diagnosis	Syphilis may be confirmed by dark field microscopic examination of exudates of lesions; serologic tests of blood and spinal fluid may also confirm the clinical diagnosis.
Mode of Transmission	Transmitted almost exclusively by sexual contact. Infection by contact with fomites (inanimate objects including toilet seats) rarely if ever occurs.
Incubation Period	10 days to 10 weeks, usually 3 weeks.
Infectious Period	It is variable. Open lesions of the primary and secondary states are very infectious. Once treated with proper antibiotics, the case becomes noninfectious usually within 24 hours.
Management of Contacts	Sexual contacts are at significant risk of infection; exposed contacts should be treated.
Management of Cases	Home isolation of patients with acquired syphilis is recommended until the person is no longer infectious, usually 24 hours after appropriate antibiotic therapy is given. The situation is obviously more complex, however, and individual evaluation is necessary.
Adults	Sexual contacts are at significant risk of infection.
Preventive Measures	Treatment of the case and tracing of contacts, as for gonorrhea, are essential to prevent further transmission of the disease.
Public Health Importance	Depending on the age of the infected person, a complex medical and legal situation may be involved. Cases of acquired syphilis in minors represent potential instances of child abuse and notification of appropriate authorities (Social Services Division, Human Services Department) may be indicated.

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The members of the School Nursing Advisory Committee for School Health wish to express appreciation to the persons mentioned. The Communicable Diseases Manual is an excellent resource tool for use by school nurses, public health personnel, and teachers in the public and private schools in New Mexico.

SCHOOL GUIDE TO COMMUNICABLE DISEASES

Recommendation for Control of Communicable Diseases in Schools

This chart is intended as a guide in the area of communicable disease control in the school setting. While every effort has been made to address the most commonly asked, and most important, questions about each disease, a chart can only present a brief summary. For this reason, this chart is not intended to substitute for individual consultations between school nurses and district health officers, public health nurses, physicians, and parents. Finally, diseases marked with asterisks (****) must be reported to the local public health office, district health officer, or the Epidemiology Office of the Health and Environment Department.

Disease	Incubation Period	Signs and Symptoms	Method of Infection	Communicable Period	Exclusion from School	Remarks
Animal Bites	Remarks: Key steps in animal bite management are designed to prevent recurrence, prevent bacterial infection, and in some cases, rabies infection. 1. Cleanse bite wound immediately with soap and water; flush copiously with water and continue washing for 5 minutes with soap and water. 2. Consult physician on possible need for tetanus prophylaxis, antibiotic treatment, or need for anti-rabies treatment. 3. If possible, restrain/catch the biting animal. Contact local animal control, local health office, or veterinarian regarding management of animal including possible need for rabies testing. 4. Obtain a complete description of the biting incident, including the circumstances of the bite, the animal's behavior, any details of the child's approach to the animal. This information will be valuable in making a decision on anti-rabies prophylaxis, especially if the biting animal has escaped.					
Chicken Pox	10-12 days; usually about 2 weeks.	First symptoms include fever and malaise. Rash develops in crops on trunk, head, and extremities. Rash lesions rapidly progress from a small spot to a blister-like lesion and then to a crusted lesion. The crusted lesions may last for 5-20 days.	Direct person-to-person by direct contact and also possibly by air-borne route. Highly contagious.	From 1-3 days before rash appears until all lesions have become crusted over.	Exclude cases until all lesions have become crusted over and no new lesions are present.	Most infectious before occurrence of rash and in early stages of eruption. Persons with depressed immunity (immuno-suppressed) should be referred immediately to doctor due to increased risk of severe chicken pox infection.
Common Cold (and common respiratory infections)	1-3 days in most cases for common cold; may be longer for some other viral respiratory infections.	The common cold needs no description; the term "upper respiratory infection" refers to infections of the respiratory tract above the larynx (not including pneumonia).	Person-to-person via respiratory secretions (saliva, mucous, sneezing, coughing); also possibly via direct person-to-person contact.	These infections are most infectious at the onset of illness and are much less infectious after several days of symptoms.	No need for exclusion in order to try to prevent spread of infection since by the time the diagnosis is made, spread has probably already occurred.	Exclusion of a child with a cold or respiratory infection may not help to reduce the spread of the disease. Unless symptoms are severe or cause class disruption, exclusion is usually not indicated.
Diarrheal Diseases	1-7 days; varies according to the cause of the diarrhea; some have longer incubation periods.	May include nausea and vomiting along with diarrhea. Fever may occur.	Method of infection varies according to age of child and type of diarrhea. Usual spread is person-to-person, sometimes via contaminated food or water.	Depends according to the cause of the diarrhea; most diarrheas infectious through virus or bacteria in stool, so that maximal infectious period coincides with period of diarrhea.	Need for and value of exclusion depends on type of diarrhea, school setting (day-care, preschool, more likely to benefit from exclusion), school population and age of child. In general, risk of spread is small if level of personal sanitation is good.	Infectious diarrheas commonly found in New Mexico include viral, parasitic, and bacterial infections. Common bacterial infections include salmonella, shigella, campylobacter. As indicated in the previous columns, the approach to diarrhea must be individualized to the epidemiologic, clinical, and bacteriological details of each case.

Disease	Incubation Period	Signs and Symptoms	Method of Infection	Communicable Period	Exclusion from School	Remarks
Diphtheria **********	Usually 2-6 days, occasionally longer.	May involve throat, nose, larynx, or skin. Typical symptoms include fever, sore throat, and weakness. Severe swelling of the neck and difficulty in breathing may occur in severe cases. Skin diphtheria may resemble impetigo and other skin infections.	Person-to-person via contact with secretions of a case or a carrier. Skin diphtheria spread by contact with skin lesions.	2-4 weeks in untreated cases; 2-4 days in treated cases. Healthy carriers may also transmit the disease.	A case of diphtheria must be excluded until determined not to be infectious by a physician.	Diphtheria is an uncommon disease in New Mexico. Cases must be reported immediately to the health officer. Immunization with diphtheria toxoid (in DPT and Td vaccines) is protective against severe manifestations of diphtheria but does not prevent the disease in all cases.
Gonorrhea **********	Usually 3-5 days, may range from 1-14 days.	Gonorrhea may be symptomatic or asymptomatic. Symptomatic illness usually causes burning on urination and penile discharge (males) or vaginal infection (females). Diagnosis must be confirmed by culture.	Person-to-person transmitted almost exclusively via sexual contact.	Untreated cases may be infectious for long periods of time; infectivity terminity rapidly after proper treatment. May lead to systemic disease if untreated.	There is no reason to exclude a child with gonorrhea from the school.	Gonorrhea in children is obviously a complex situation, requiring immediate individual evaluation. Child abuse must be considered as having occurred until proven otherwise.
Hepatitis, Infectious ***********	15-50 days; usually 20-30 days.	Children, especially young children, may have mild gastrointestinal or nonspecific illness. Classic hepatitis has nausea, vomiting, loss of appetite, yellowing of skin and whites of eyes (jaundice), darkening of urine.	Fecal-oral spread; may be foodborne or waterborne. Virus is present in stools of infected persons. No carrier state exists.	1-2 weeks before jaundice until 1 week after onset of jaundice; most infectious just before onset of jaundice in classic cases.	Need for exclusion dependent on age of child and type of school setting. In general, risk of spread is small in classroom setting beyond kindergarten age.	Many cases will be asymptomatic and unrecognized. Good personal hygiene will prevent person-to-person spread. Gamma globulin rarely needed in school setting except possibly preschool environment. Contact local health office to report cases and for guidelines.
Impetigo	2-5 days.	Skin infection with pustules, vesicles, and crusted areas most common.	Direct person-to-person spread among children.	Unknown; proper treatment makes case noninfectious earlier.	Must be individualized; may be reasonable to exclude child until 24 hours after antibiotic treatment started.	Occurs year-round, although probably more common in late summer and early fall. Younger children more commonly affected. Treatment may prevent late complications of streptococcal skin infection.
Infectious Mononucleosis	2-6 weeks.	Fever, sore throat, weakness, enlargement of lymph nodes.	Probably person-to-person via respiratory secretions, but seems to require prolonged and/or intimate contact.	Unknown.	No public health reason to exclude a child with "mono." Minimally infectious in school room setting.	Laboratory work needed to confirm diagnosis. No specific treatment for "mono." Fatigue related to "mono" may be severe and last for months.
Influenza	1-3 days.	Fever, headache, malaise, sore/scratchy throat, cough, muscle aches.	Person-to-person through respiratory droplets from nose and throat.	Most infectious just before start of symptoms; infectious period ends about 3 days after onset of illness.	By the time influenza is diagnosed, child is usually ill and stays home.	Influenza occurs in epidemic form. Viral spread within a school is often rapid. Influenza vaccines should be used for "high-risk" children (children with certain chronic illnesses).

Disease	Incubation Period	Signs and Symptoms	Method of Infection	Communicable Period	Exclusion from School	Remarks
Measles *******	10-12 days.	Prodrome of fever, cough, red, watery eyes, and head cold symptoms (coryza). 2-4 days later, rash appears first on face then spreads to trunk and legs.	Highly infectious. Spreads person-to-person via respiratory droplets.	7 days before rash appears to 7 days after rash appears.	Cases of measles should be excluded until 7 days after rash appears.	Measles can spread in outbreaks. Measles has severe complications such as brain inflammation, ear infection, and pneumonia. Measles vaccine is highly effective in preventing measles. Suspect measles must be reported immediately to the local health office.
Meningococcal Disease (Includes Meningitis) **********	2-10 days; usually 3-5 days.	Severe, life-threatening infection with high fever, stiff neck, headache, vomiting, and possibly stupor or loss of consciousness.	Person-to-person through droplet spread or contact with respiratory secretions. Healthy carriers may be a source of infection.	Healthy carriers are potentially infectious; cases noninfectious within 24 hours after start of antibiotic treatment.	This life-threatening illness will be evaluated by a physician and will require hospitalization.	Many people carry the bacteria (Neisseria meningitidis) in their throats and never become ill. Need for protection of contacts to a case must be evaluated rapidly by the health department. A rare disease.
Mumps	12-26 days; average of 18 days.	Fever, swelling of salivary glands, especially the parotid gland located behind the angle of the jaw and below the ear.	Person-to-person via respiratory droplets.	7 days before swelling of glands until about 9 days after swelling begins.	Exclude cases from school until gland swelling has disappeared (7-10 days in most cases).	Mumps vaccine is available and is effective.
diculosis (Head Lice)	Once the lice are present, infestation begins.	Itching on the nape of the neck and behind the ears. Scratching may lead to secondary bacterial infection.	Lice can be transmitted by close personal contact, but more frequently transferred on objects such as coats, hats, and brushes.	A person with head lice is potentially communicable until lice are eradicated.	Child with head lice should be excluded until given first treatment with specific anti-lice medication. Return to school only with evidence that anti-lice treatment has been given.	Clothing worn by child with lice must be laundered and other personal objects treated. A second treatment with anti-lice medication may be necessary 10 days after the first treatment. No real correlation between child's sanitary state and risk of contracting head lice. Control in school setting may be complex.
Pertussis	7-10 days.	Runny nose and mild cough in first stage; severe whooping cough in second stage.	Person-to-person via respiratory route.	Most infectious during first phase when hard to identify; untreated case may be infectious for 2-3 weeks; antibiotic treatment makes case noninfectious within days.	Exclude from school until at least 1 week on proper antibiotic treatment or 3 weeks after onset of cough in untreated cases.	Epidemics may occur. Fully immunized children may get pertussis but most cases occur in unimmunized or partially immunized children. Essential to notify local health office.
Pinkeye (Epidemic Conjunctivitis)	24-72 hours.	Inflammation of one or both eyes with irritation, watery eyes, and redness. Light may be painful to eyes, lids may be swollen, and pus may collect causing eyelids to be crusted or sticky.	Person-to-person spread by fingers or objects contaminated by discharge from eye or upper respiratory tract.	During active infection.	During acute state of illness.	Conjunctivitis may be caused by bacterial or viral infection, or it can be allergic. Conjunctivitis caused by adenovirus type 3 is highly contagious and can cause syndrome with fever, sore throat, malaise and lymph node swelling. Spread of pinkeye can be epidemic, especially among young children.

Disease	Incubation Period	Signs and Symptoms	Method of Infection	Communicable Period	Exclusion from School	Remarks
Polio *****	3-21 days; usually 7-12 days.	Mild polio may cause fever, headache, sore throat and gastrointestinal complaints. Severe polio progresses to paralysis.	Person-to-person via contact with saliva or feces of infected person.	Variable; most infectious for several days before to 1 week after onset of illness.	Exclude from school for at least 1 week after onset of symptoms.	Thanks to vaccine, this is an extremely rare disease. Any suspect case must be reported immediately. Polio occurs in Mexico and many other parts of the world.
Ringworm of Body	1-3 weeks.	Flat, spreading ring-shaped lesions of skin.	Contact with infected persons, animals, or contaminated materials.	Until lesions are eradicated.	No need for exclusion from school but exclude from certain activities (gym, swimming).	Fungal disease; a disease of man and animals.
Ringworm of Feet (Athlete's Foot)	2-3 weeks.	Peeling, scaling, and cracking of skin, especially between the toes. Lesions may also occur on hands.	Contact with skin flakes, especially in damp environment.	Until lesions and fungus are eradicated.	Not necessary; limit use of public areas by persons with active infection such as gym locker room.	Fungal disease; prevention depends on good foot hygiene. Treatment of patients with active infections is important.
Ringworm of Scalp	2-3 weeks.	Round scaly patches; hair brittle and breaks off easily.	Person-to-person spread by direct contact or indirect contact on clothing or other fomites.	Until lesions are eradicated.	Exclude until under treatment and strategy to prevent spread is undertaken.	Highly communicable. Diagnosis often by "Woods light." Fungal disease.
Rubella ********	14-21 days.	Rash often first sign of illness in children. Prodrome of fever, malaise, and headache may exist for 1-4 days. Rash first on face, then rapidly over entire body. Difficult to diagnose with certainty on basis of signs and symptoms.	Person-to-person via throat and nasal secretions; airborne and direct contact.	7 days before rash until 5 days after rash starts.	Exclude cases until 5 days after onset of rash.	Rubella vaccine is effective. Goal of rubella control is to prevent infection of susceptible pregnant women. Suspect cases must be reported immediately.
Scabies	Often as long as 4-6 weeks.	Intense itching, usually worse at night. Itching occurs between fingers, on wrists, elbows, armpits, ankles, feet, buttocks, and at waistline. Usually spares the head.	Person-to-person via direct skin contact; bedding and clothing may play a role.	Communicable until mites and eggs are destroyed.	No reason for exclusion.	Transmission from person-to-person unlikely in school setting; household unit is crucible for transmission. Easily superinfected with impetigo which requires separate treatment.
Strep Throat and Scarlet Fever	2-5 days.	Classic strep throat has fever, tender lymph glands in neck, pus-like exudate on tonsils. Cases may occur with minimal symptoms. Scarlet fever usually has strep throat symptoms plus a rash. Rash is fine and often spreads over the entire body.	Person-to-person via respiratory secretions and saliva.	If untreated, may be contagious for weeks; usually infectious within 24 hours after penicillin treatment.	Exclude from school until treatment is under way for at least 24 hours.	Importance of treating streptococcal infections due to concern about later complications (rheumatic fever). May occur in outbreaks; notify health office if outbreak occurs.

SUGGESTIONS FOR SCHOOL EMERGENCY PROCEDURES

FIRST AID

Developed in coordination with the New Mexico School Nurses Advisory Committee

GENERAL PRINCIPLES

Time is of utmost importance in giving first-aid for the following: (1) to restore breathing; (2) to prevent shock or further injury; and (3) to counteract oral poisoning. Send word to the school person assigned to be responsible during health emergencies. Notify the emergency medical system for transportation.

Notify the parents. If they can be consulted immediately, find out which physician or dentist is to be secured or to which medical or dental facility the child should be taken. (Such information should always be on "authorization" cards, signed by the parents for each pupil in case parents cannot be reached.)

Stay with the child until the parent or doctor assumes responsibility. Have him/her lie down.

Internal medication (including aspirin) should be given only by, or on order of, a physician or dentist. Do not give fluids to an unconscious person.

Do not move a seriously injured child unless absolutely necessary. If a child must be pulled to safety, pull in the direction of the long axis of the body, not sideways.

PRIORITY EMERGENCIES

Cessation of Breathing. Drowning, electric shock, or choking:

1. Give artificial respiration AT ONCE and at the site of the accident. Cardiopulmonary resuscitation (CPR) is the preferable method in most situations. All first-aid specialists should demonstrate ability to perform CPR and should realize the need for its continuous application until breathing is restored or until careful repeated medical examination advises otherwise.
2. If the child is choking and gasping for breath, perform Heimlich procedure. Stand behind patient, place arms around patient and hands together just below patient's breastbone. Move hands up and in force fully, creating pressure on chest and back bones.
3. If electric shock, do not touch patient while he/she is in contact with current. Break the contact (a) by turning off the current or (b) by separating the victim from the current with a dry piece of wood.
4. In the case of electric shock, after breathing is restored, take care of burns.

Bleeding. Moderate bleeding can be controlled by placing a clean pad over the wound; apply additional pads as needed, without moving any; press firmly with fingers or hand; elevate the bleeding part above the rest of the body; keep the person lying down; call a physician if bleeding cannot be controlled in this manner.

Never use a tourniquet to control bleeding except for amputated, mangled, or crushed arm or leg. The decision to apply a tourniquet is in reality a decision to risk the sacrifice of a limb in order to save a life. If used, a tourniquet should be a strong wide piece of cloth, tightened only sufficiently to stop bleeding. If surgery may be needed, give the patient nothing by mouth. A properly applied tourniquet can be left in place for 1 or 2 hours, and should be released only by qualified medical personnel.

Since there may be a possibility of internal bleeding, if the victim must be moved, move in a lying position only.

Priority Emergencies, Continued

Shock. Common symptoms of shock are: pallor; cold, clammy skin; and a rapid, weak pulse. There may also be weakness, mental confusion, and vomiting. Early and adequate shock treatment is lifesaving. DO NOT DELAY. Notify the emergency medical system. Until the physician takes over:

1. Keep the patient comfortably warm, but avoid overheating.
2. Keep the patient on his/her back with feet elevated and head low unless there is a head injury, difficulty in breathing, or the patient complains of pain when this position is assumed.

Poisoning (Oral). Call the Poison Control Center (in Albuquerque, call 843-2551; the rest of the state should call 1-800-432-6866) at once. Follow their directions closely. Have syrup of ipecac handy (not extract of ipecac).

MAJOR INJURIES

Deep Cuts. Apply dressing. Control bleeding as previously described under "Bleeding." Seek medical care and advice. Check on status of tetanus immunization.

Suspected Fractures or Dislocations

1. First-aid should do no more than prevent further injury. A physician's attention is needed at once. Notify emergency medical system.
2. Do not move patient unless necessary. If patient must be moved, do not do so unless the affected part can be immobilized. Do not attempt to straighten a dislocated joint or broken bone.
3. Apply splints without moving limb.
4. Apply cold compresses or ice pack to affected part. If skin is broken, cover the area with dry, sterile dressing. Do not cleanse.
5. Treat shock if signs are present.

Major Burns. (Deep burns where skin is charred or burns involving large areas of the body or where there is extensive blistering.)

1. Thermal Burns
    a. Remove any burning or hot clothing.
    b. Apply ice to small burns at once.
    c. If the burn is extensive, wrap the affected body area in a clean towel or sheet to exclude air. Transfer to a hospital immediately. Do not try to remove clothing that is adherent to the burned area.
    d. Prevent or treat shock. Keep patient warm; do not overheat.
    e. Do not apply ointment or anything else. Leave blisters alone.
2. Chemical Burns
    a. Remove clothing of affected area.
    b. Drench repeatedly with water for 20 minutes, including areas of skin touched each time by the water; then treat as any similar burn.
    c. Treat for shock, if area affected is extensive, and call a physician.

Bites and Stings

1. Dog Bites
    a. Cleanse wound repeatedly with soap and water, rinse, and cover with dry, sterile dressing.
    b. All dog and other animal bites should be referred to a physician for decision with regard to necessity for rabies immunization and suturing.
    c. The biting animal should either be confined for observation, or killed and the brain sent for a rabies examination. Consult with the doctor, local animal control officer, or the Epidemiology Office regarding management of the animal.
2. Snake and Black Widow Spider Bites. Carry the victim to a physician or hospital immediately.

Major Injuries, Continued

3. Miscellaneous Insect Bites and Stings

   a. Use ice pack or cold applications over area of bite or sting.

   b. Remove bee stinger with scraper.

Eye Injuries. Any injury to the eye should receive prompt medical attention.

1. Chemical Burns. Irrigate chemical burns of the eye copiously and at once with water only. Continue to irrigate with water for at least 20 minutes by the clock. IT IS MOST IMPORTANT to start water irrigation promptly. Then call Poison Control.

2. Hot Metal Burns. Apply sterile pad and refer at once to physician. Irrigate with water. Check with ophthalmologist.

3. Foreign Bodies. The first-aider should attempt to remove only those foreign bodies from the eye which can be readily located and which can be gently washed out with water or removed with a sterile cotton applicator. Physician's care is essential if the foreign body cannot be readily located, if it is imbedded, or if irritation or pain persists after removal. Temporary relief can be obtained by a firmly applied bandage over the eye. Prevent child from rubbing the eye.

4. Blow to the Eye. Sudden blindness following a blow to the eye may indicate hemorrhage. Keep the patient quiet and lying down. Shield both eyes. Call physician immediately.

Head Injuries. Until the physician takes over:

1. If chance of neck injury (usually there is in head injury), place patient carefully on back, holding head straight ahead with sandbags.

2. Keep patient quiet and warm. Hurried transportation is a grave danger. Observe patient carefully for nausea and prevent aspiration should vomiting occur by placing patient on side or face down while maintaining alignment until physician or paramedic arrives.

Back Injuries. Careful handling of the victim is extremely important. If you suspect an injury, do not move patient. Contact school medical advisor to assess patient's condition. Severe pain, tingling, or numbness in back or limbs may indicate a serious injury.

ACUTE ILLNESS

The child with symptoms of acute illness should lie down and be under constant observation in the nurse's or the school office. Parents should be notified to call for the child and advised to consult the family physician. Otherwise, arrangements should be made to return the child to his/her home. No child should, however, be sent home unaccompanied by a responsible person or without knowledge that one of the parents is at home. If the parent or relative cannot be located, the child should be segregated from other children in a quiet room until parents can be found; or, if the condition demands it, the advice of the family physician may be sought in accordance with school emergency authorization policies.

Fainting. Have patient lie down until recovery is complete. Aromatic spirits of ammonia may be used. Give nothing by mouth. If the patient does not recover consciousness almost immediately after lying down, medical advice should be sought as the case is not simple fainting.

Abdominal Pain. Any person with persistent and severe abdominal pain which lasts more than a short time should be seen by a physician. Do not give food, drink, or medication. Do not use abdominal compresses or heat.

Nosebleeds. Keep the patient quiet. The nose should be pinched firmly at midline between fingers for five to ten minutes without letting up pressure, preferably with the patient sitting. Caution the patient not to blow his/her nose for an hour or two after bleeding stops. A physician should be consulted if bleeding continues.

Acute Illness, Continued

Epileptic Convulsions. An epileptic seizure is not a medical emergency. Keep the patient from injuring himself/herself by removing nearby objects, but do not try to restrain him/her. Do not attempt to place anything in the mouth. The attack is usually over in a few minutes and is followed by drowsiness. Allow the patient to rest. If the convulsion lasts for more than five minutes, call a physician. A lack of prior knowledge of seizure activity should be reason to refer for emergency treatment.

Hypoglycemia. If a child known to have diabetes becomes faint or "shaky," give sugar in any form (orange juice is also good) and notify a parent. Standing orders from the family physician should be on hand for such children and should be known to teachers involved.

Overexposure to Heat and Cold

1. Heat Exhaustion. Skin is pale and clammy, and temperature may be normal. Treat for shock. If patient is conscious, give Gatorade or solution of ½ teaspoonful of salt per quart of water to drink every 15 minutes for three or four doses. Put victim in a cool place, and ask him/her to lie down.
2. Heat Stroke. Skin is red, hot, and dry and temperature is high. Have patient lie down in a cool place. Apply cold pack to head. Cool body by sponging with water or alcohol. Call a physician and transport patient to a hospital as soon as possible.
3. Sunburn. Give first-aid as indicated for other burns.
4. Frostbite. Bring person inside as soon as possible. Place frostbitten part in lukewarm water. Do not rub affected parts. Consult physician.

Heart Attack. Place in a comfortable position, usually sitting up (if short of breath). If not breathing, begin artificial respiration and have someone call for an ambulance. Check pulse; if no pulse, begin cardiopulmonary resuscitation. Do not attempt to transport victim. Get medical advice.

Ears

1. Earache. Advise parents to take child to a physician.
2. Foreign Bodies in the Ear. Refer to a physician.

MINOR INJURIES

Abrasions (Scrapes or Scratches to the Skin) and Minor Cuts. Clean thoroughly with soap and water and rinse. Apply dry, sterile dressing. For cuts inside the mouth, have patient rinse mouth repeatedly with cold water or hold ice chips in mouth. Check tetanus immunization.

Bruises. Apply cold compresses immediately following injury.

Puncture Wounds. Deep puncture wounds through the skin need prompt medical attention. If very superficial, clean and apply sterile dressing. Check on status of tetanus immunization.

Slivers and Splinters. Remove with tweezers or sterilized (flamed) needle after the skin has been thoroughly washed. Wash skin again after removing sliver or splinter. Check on status of tetanus immunization.

Burns and Scalds. Place pad over the burn and bandage loosely. DO NOT use ointment of any kind. If skin is not broken, immerse part in clean cold water or apply ice to relieve pain. Leave blisters alone. (For major burns, see Major Injuries.)

Chemical Burns. Flush immediately with running water; repeat several times and include areas of the skin that flushed water touches; then treat as any similar burn.

Sprains and Strains. Elevate the part and keep the patient at rest. Apply cold compresses or ice bag during the first half hour. Consult a physician if pain persists or fracture is considered possible.

Dog and Other Animal Bites. See Major Injuries.

Blisters Other than Burns. Whether closed or open, wash thoroughly with soap and water. Rinse and pat dry. Cover with dry, sterile dressing unless it is infected.

PROCEDURAL MANUAL
for Enforcement of the
SCHOOL IMMUNIZATION LAW

1912

New Mexico Statutes Annotated 1978 Compilation

Sections 24-5-1 through 24-5-6

INTRODUCTION

The purpose of this manual is to provide all pertinent information on the implementation of the school immunization law in a single publication. This compilation should help to minimize confusion about New Mexico State Department of Education or New Mexico Health and Environment Department regulations, and about the basic school immunization law itself.

As a result of close collaboration between the Department of Education and the Health and Environment Department, a mutual understanding has been reached about all procedures involved in implementation of the immunization law. Accordingly, the following materials are presented in this publication:

A flow-chart designed to present the essential courses of action open to any student presenting for enrollment in New Mexico schools;

A commentary on the flow-chart intended to provide additional information on certain important matters;

State Board of Education regulations 76-16 and 76-17;

Health and Environment Department regulations pertinent to the school immunization law;

Reporting requirements and procedures; and

New Mexico Statutes 24-5-1 through 24-5-6 which establish the immunization law.

The Health and Environment Department will publish a schedule of vaccinations required for compliance with the school immunization law. This schedule will generally be published in the Spring for application during the school year to begin in Summer-Fall of the same year.

We hope that this compilation will assist you in administration of your specific responsibilities as defined under state statutes and regulations.

DEPARTMENT OF EDUCATION

HEALTH AND ENVIRONMENT DEPARTMENT
HEALTH SERVICES DIVISION

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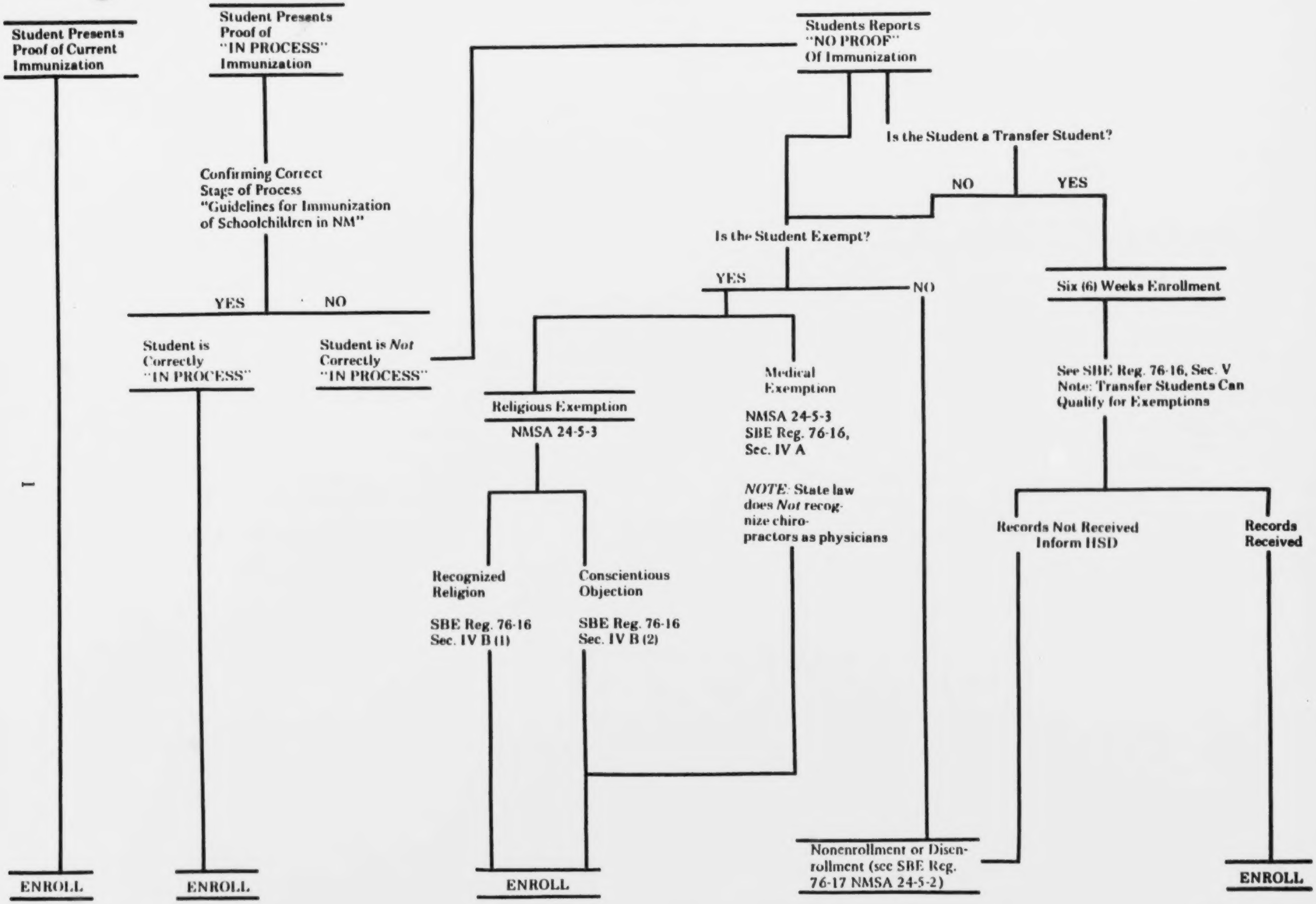
Revised 10/82


Student Presents Proof of Current Immunization
Student Presents Proof of "IN PROCESS" Immunization
Students Reports "NO PROOF" Of Immunization
Is the Student a Transfer Student?
NO
YES
Confirming Correct Stage of Process "Guidelines for Immunization of Schoolchildren in NM"
Is the Student Exempt?
YES
NO
Six (6) Weeks Enrollment
YES
NO
Student is Correctly "IN PROCESS"
Student is *Not* Correctly "IN PROCESS"
Medical Exemption
Religious Exemption
NMSA 24-5-3
NMSA 24-5-3
SBE Reg. 76-16, Sec. IV A
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Records Received
Recognized Religion
SBE Reg. 76-16 Sec. IV B (1)
Conscientious Objection
SBE Reg. 76-16 Sec. IV B (2)
ENROLL
ENROLL
ENROLL
Nonenrollment or Disenrollment (see SBE Reg. 76-17 NMSA 24-5-2)
ENROLL

PROCEDURAL FLOW CHART WHEN STUDENT PRESENTS FOR ENROLLMENT

COMMENTARY ON PROCEDURAL FLOW CHART

1. STUDENT PRESENTS FOR ENROLLMENT:

   A. §24-5-2, NMSA, reads:
   "It is unlawful for any student to enroll in school unless he has been immunized, as required under the rules and regulations of the health services division of the health and environment department, and can provide satisfactory evidence of such immunization. Provided that if he produces satisfactory evidence of having begun the process of immunization, he may enroll and attend school as long as the immunization process is being accomplished in the prescribed manner. It is unlawful for any parent to refuse or neglect to have his child immunized, as required by this section, unless the child is properly exempted."

   B. Thus, every presenting student's immunization status must be reviewed against the current immunization schedule prior to enrollment every year. Students presenting themselves for enrollment will by their circumstances be identified as transfer students or non-transfer students.

   NON-TRANSFER students will be further characterized as either 1) demonstrating proof of current immunization status, in which event they should be enrolled, or 2) demonstrating proof of being "in process" of becoming currently immunized, in which event they should be enrolled and their status reviewed to insure completion of the process, or 3) having no proof of their immunization status. For non-transfer students who have no proof of their immunization status, the first inquiry should be whether or not the presenting student is entitled to be exempted from compulsory immunization pursuant to 22-5-4, NMSA, 1978 or the Attorney General's opinions on medical exemptions [No. 59-96], or on religious exemptions [No. 75-69] and the Department of Education's Regulation No. 76-16 (IV) and the Health and Environment Department's Regulation entitled, "Religious Exemption from School Immunization." Non-transfer students who have no proof of their immunization status and who are not entitled [illegible] an exemption must not be enrolled.

   Students identified as TRANSFER should be enrolled pursuant to the Department of Education's Regulation No. 76-16 (V); that is, they should be conditionally enrolled for a period not to exceed six weeks during which time they must 1) obtain proof to demonstrate current immunization status, or 2) begin and establish enrollability as "in process" of becoming currently immunized, or 3) apply for a medical or a religious exemption from comuplsory immunization.

   C. Students who supply physician's certificates of medical exemption must be enrolled unconditionally upon presentation for enrollment. Students who supply a denominational officer's affidavit of membership or a parent's or guardian's certificate of conscientious objection must be conditionally enrolled for a maximum period of sixty (60) days; and all such affidavits or certificates claiming religious exemption must be transmitted from the particular child's school principal, through the district superintendent to the director of the Health Services Division for approval or disapproval. Upon notice from the Health Services Division director that the claimed religious exemption is approved or upon expiration of sixty days from the date the child supplies the religious exemption affidavit or certificate, the child's enrollment must be changed from conditional to unconditional.

2. DISENROLLMENT [See Department of Education Regulation No. 76-17]

   A. If a non-transfer student was conditionally enrolled on the basis of satisfactory evidence of having begun the process of immunization but fails to continue the process according to the prescribed schedule; or

   B. If a non-transfer student was conditionally enrolled on the basis of a denominational official's affidavit or a parent's or legal guardian's certificate of conscientious objection, but receives notice of disapproval of the claimed religious exemption before the expiration of sixty d[illegible] from the date supplied; or

C. **If a transfer student at the expiration of six weeks from the date they were conditionally enrolled fails to provide satisfactory evidence that they have complied with the compulsory student immunization requirements in one of the five manners set out at the first paragraph, or hereinabove;**
THEY MUST BE DISENROLLED ACCORDING TO THE PROCEDURE SPECIFIED IN DEPARTMENT OF EDUCATION REGULATION NO. 76-17.

3. ENFORCEMENT

The compulsory student immunization law provides:

A. *". . . It is unlawful for any parent to refuse or neglect to have his child immunized, as required by this section, unless the child is properly exempted."* [24-5-2, NMSA, 1978] A parent may be prosecuted for violation of the requirements of the compulsory student immunization law and the compulsory school attendance law. Such prosecutions may be brought in Magistrate Court through the local offices of District Attorneys by the Health and Environment Department in concert with the Department of Education when (1) the child is refused enrollment or (2) when the child has been disenrolled.

B. *". . . It is unlawful for any student to enroll in school unless . . ."* [24-5-2, NMSA, 1978]
Enforcement of the prohibition against enrollment except as indicated herein is the function of the individual schools and local school districts. Failure of the school principal and the local school superintendent to perform the enforcement function in the first instance upon the child's presentation for enrollment or later when the prerequisites for conditional enrollment have expired or otherwise ceased to exist may be prosecuted as misdemeanors in Magistrate Court through the local offices of District Attorneys or as civil actions in the nature of mandamus in the District Courts by the Health and Environment Department in concert with the Department of Education.

C. *". . . It is the duty of each school superintendent, whether of a public, private or parochial school, to cause to be prepared a record showing the required immunization status of every child enrolled in or attending a school under his jurisdiction. These records must be kept current and available to public health authorities . . ."* [24-5-4, NMSA, 1978]
Enforcement of the superintendent's reporting and record keeping function may be prosecuted as a misdemeanor in Magistrate Court through the local offices of the District Attorneys or as a civil action in the nature of *mandamus* in the District Courts by the Health and Environment Department in concert with the Department of Education.

D. *". . . Violation of any provisions relating to the immunization of school children is a misdemeanor."* [24-5-6, NMSA, 1978]

4. COOPERATIVE RELATIONSHIP BETWEEN DEPARTMENT OF EDUCATION AND HEALTH AND ENVIRONMENT DEPARTMENT

A. §24-5-1, NMSA, 1978, reads in pertinent part:
"The state board of public health, [now Health and Environment Department] shall after consultation with the state board of education, promulgate rules and regulations governing immunization . . . of children attending public, private or parochial schools in the state . . ."
and
". . . The state department of public health [HED] shall supervise and secure the enforcement of the required immunization program."

B. Opinion of the Attorney General No. 59-96, reads in pertinent part:
". . . In arriving at our conclusion and opinion that the state department of public health [HED] is charged and made responsible for the enforcement of the provisions of said section [the superintendent's duty to report] of the statute, we have considered the direct and clear language of the statute, neither adding nor subtracting from the same. Since any violation of this statute amounts to a misdemeanor the department . . . can undoubtedly obtain the help of the district attorneys and the justice of the peace [now, Magistrate] in the state and precinct . . ."

C. Opinion of the Attorney General No. 75-69, reads in pertinent part:
"... *We would suggest, therefore, that the rules and regulations of the Health and Environment Department be amended to contain alternatives to the specific requirement of an affidavit from an officer of a religious organization* ..."

D. Opinion of the Attorney General No. 75-70, provides in pertinent part:
"... *In order to insure uniformity of application, it is our recommendation that the State Board of Education promulgate regulations regarding 'disenrollments' pursuant to noncompliance with Section 24-5-2 ..., in conjunction with the [Health and Environment Department] which has supervisory and enforcement responsibility pursuant to Section 24-5-1* ..."

E. Thus, while the Health and Environment Department has the lead role in the prescription of immunization and the enforcement of the compulsory student immunization law, it does not have control over all the elements which make up the process; and it cannot, in the absence of seeking intervention by a court, accomplish universal compliance with the scheme without the cooperation and assistance of school authorities. HED must rely upon the schools to refuse enrollment to non-complying children presenting themselves in the first instance, it must rely upon the schools to insure that students who are conditionally enrolled at first do complete the process of immunization or do accomplish religious exemption; and it must rely upon the schools to disenroll students whose conditional enrollment ceases to be viable. Further, the Health and Environment Department must rely upon the schools for the names and addresses of the parents of students refused enrollment and disenrolled. And in a larger sense, the Health and Environment Department must rely upon the good faith of school authorities to raise logistic and administrative considerations in timely fashion so that immunization clinics and special efforts to make immunizations available in particular circumstances can be scheduled in the most appropriate fashion. In turn, the school authorities must rely upon the Health Services Division of HED to prescribe the most effective immunization schedule according to the most current data and to give them adequate lead time for accomplishing the goals that are agreed upon. All of this requires that school authorities and Health Services Division immunization program personnel maintain close and open communication and that they respond to one another's inquiries and concerns in a spirit of mutual cooperation.

REGULATION NO. 76-16
IMMUNIZATION OF SCHOOL CHILDREN

I. *Authority.* This regulation is promulgated pursuant to Section 24-5-2, NMSA, 1978 Comp. (being Laws of 1959, Chapter 329, Section 2, as amended by Laws of 1975, Chapter 25, Section 1) and Section 24-5-3, NMSA, 1978 Comp. (being Laws of 1959, Chapter 329, Section 1).

II. *Limitations on Enrollment.* Subject to the provisions of Paragraph 5 of this regulation, no student shall be enrolled in the public, private or parochial schools in the state unless the person has been immunized in accordance with the requirements of the health and environment department regulations and the student can produce satisfactory evidence to the administrative authority that the immunizations have been completed or that the student seeking enrollment can produce satisfactory evidence that he or she has begun the process of immunization and the immunization process is being accomplished in the manner and pursuant to the limitations contained in Paragraph IV of this regulation.

III. *Definitions*

A. "administrative authority" means the superintendent, principal or the designee of such person.

B. "director of the state health agency" means the director of the health services division.

C. "health services division regulations" means those regulations adopted by the health services division pursuant to the authority granted in Sections 24-5-1 to 24-5-6, NMSA, 1978 Comp., and including an Immunization Schedule.

D. "licensed physician" means a physician licensed to practice medicine or osteopathic medicine in New Mexico, another state or territory.

E. "required immunizations" means those immunizations against diseases deemed to be dangerous to the public health by the health services division and set forth in its Immunization Schedule effective at date of enrollment.

F. "satisfactory evidence of commencement of and completion of immunization" means satisfactory evidence of a person having begun the process of immunization in a statement, certificate or record signed by a duly licensed physician or other recognized public or private health facility stating that the person has received at least the first in the series of required immunizations and is proceeding with immunization according to the prescribed schedule.

Persons enrolling in schools who have begun the process of immunization shall have three months following the date of enrollment to complete the required immunizations and submit satisfactory evidence of completion of the required immunizations which shall be in the form established by Paragraph III G of this regulation.

G. "satisfactory evidence of immunization" means a statement, certificate or record signed by a duly licensed physician or other recognized, licensed health facility stating that the required immunizations have been given to the person.

IV. *Exemptions from Immunization.*

A. Medical Exemption. Any child under the age of 18, through his parent or guardian, or any student over the age of 18, may obtain an exemption from obtaining the required immunizations for a period not to exceed nine (9) months, by filing a statement or certificate with the director of the health services division signed by a licensed physician stating that the physical condition of the person seeking enrollment is such that immunization would seriously endanger the life or health of the person.

B. **Religious Exemption.**

1. Exemption by membership in recognized religious denomination: Any parent or guardian belonging to a recognized religious denomination whose religious teaching requires reliance upon prayer or spiritual means alone for healing shall present affidavits from an officer of the denomination stating that the parents or guardians are *bona fide* members of said recognized religious denomination and that the religious teaching of the denomination requires reliance upon prayer or spiritual means alone for healing. Upon filing such affidavit, the child is exempt from legal requirement of immunization for a period not to exceed nine (9) months.

2. Exemption by certificate of religious objection: A parent or guardian who cannot obtain an affidavit from an officer of a recognized religious denomination as described in Paragraph 1, hereof, but whose religious beliefs, held either individually or jointly with others, do not permit the administration of vaccine or other immunizing agents, may apply for an exemption from immunization by submitting a certificate of conscientious objection to immunization.

   a. Oath. The certificate must be signed in the presence of a notary public.

   b. Conditional enrollment. Upon presentation of a notarized certificate to the principal of the school to which a child seeks enrollment, the principal shall allow the child to be enrolled conditionally until such time as the certificate is either approved or disapproved by the director of the health services division.

   c. Grounds for disapproval. The director of the health services division or his designee may disapprove a certificate for failure to fully complete it or for failure to allege beliefs and practice sufficient to warrant an exemption from immunization for religious reasons consistent with the legislative intent of Section 24-5-3, as explained in opinion of the Attorney General No. 75-69, dated December 8, 1975.

   d. Role of superintendent. Every principal receiving a certificate of conscientious objection to immunization shall deliver the same to the superintendent of schools for the district by which the principal is employed within seven (7) days of the time the certificate has been received; the superintendent shall note on his or her records that a religious exemption has been claimed on behalf of each child so claiming and forward the original certificate to the director of the health services division within seven (7) days of the time it has been received from the school principal.

   e. Duties of state director: Pursuant to authority granted in Section 24-5-3, *supra*, within sixty (60) days of his receipt of a certificate of conscientious objection to immunization, the director of the health services division or his designee shall (i) determine whether the certificate has been duly completed and notarized; (ii) make or cause to be made such investigation as may be appropriate to ascertain that the exemption is a *bona fide* claim of religious beliefs and practice; (iii) advise in writing the parent or guardian of the subject child, and the superintendent of the school district in which the child's school is located, and the principal of the school at which the child has been conditionally enrolled that the claimed religious exemption has been approved or disapproved. In the case of disapproval of claim to religious exemption, the director of the health services division, or his designee shall state the reason or reasons therefore in the letter of notification.

   f. Right to appeal: Every parent or guardian of a child whose claim on behalf of that child for religious exemption from the student immunization requirements is disapproved by the director of the health services division or his designee, shall have the right to pursue an administrative appeal from such disapproval. The manner and method of administrative appeal shall be determined by the director of the health services division.

C. Renewal of Exemption. Any certificate for exemption under this section may be renewed at the expiration of the nine month period by filing a new certificate meeting the requirements of this section. A renewal certificate shall only exempt the person for nine months from the date of refiling.

V. *Transfer of Students.* Not withstanding any other provisions hereof, a transferee from another school district in New Mexico or from any school outside the state of New Mexico, shall be allowed to enroll conditionally, until such time as proof of immunization is received from his former school or licensed physician, provided however that such conditional enrollment shall not exceed six (6) weeks from the date of enrollment, and if there is in the opinion of the administrative authorities a good faith effort to comply with the provisions of the immunization law.

VI. *Disenrollment.* If satisfactory evidence of immunization is subsequently determined to be incorrect for any reason, and the person enrolled has not completed the required immunization, or if a person having begun the process of immunization does not complete the process in a timely manner, or does not submit evidence of completion within the time limits set forth in Paragraph III F of this regulation, or an exemption is determined to be invalid, the administrative authority shall commence disenrollment proceedings.

VII. *Disenrollment Proceedings.* Disenrollment proceedings shall be governed by the procedures established in State Board of Education Regulation 76-17, relating to disenrollment.

VIII. *Superintendent's Duty to Report.* It is the duty of each school superintendent, whether of a public, private or parochial school, to cause to be prepared a record showing the required immunization status of every child enrolled in or attending a school under his jurisdiction.

A. These records must be kept current and available to public health authorities.

B. The name of any parent or guardian who neglects or refuses to permit his child to be immunized against diseases as required herein shall be reported by the school superintendent to the director of the health services division, within a reasonable time after such facts become known to the superintendent.

IX. *Repeal.* This regulation supercedes and repeals State Board of Education Regulation 76-T, adopted by the Board June 24, 1976.

Adopted by the State Board of Education, August 26, 1976.

REGULATION NO. 76-17
DISENROLLMENT PROCEDURE WHEN A STUDENT IS NOT LEGALLY ENROLLED IN SCHOOL

I. *Authority*. This regulation is promulgated pursuant to Section 22-2-2, NMSA, 1978 Comp. (being Laws 1967, Chapter 16, section 5, as amended by Laws 1969, Chapter 180, section 2. Laws 1971. Chapter 263, Section 2 and Laws 1975, Chapter 332, Section 2.) and Section 24-5-2, NMSA, 1978 Comp. (being Laws 1959, Chapter 329, Section 2, as amended by Laws 1975, Chapter 25, Section 1.)

II. *Definitions*. As used in this regulation the following words, terms and phrases shall have the meaning set forth in this paragraph:

A. "administrative authority" means the superintendent, principal or the designee of such person.

B. "disenrollment" means discontinuance of the student's right to attend school.

C. "enrollment" means registration as a student on the rolls of the local school district.

D. "invalid enrollment" refers to an enrolled student or a conditionally enrolled student who has not met the requirements of law for enrollment in school, either as to age, residence, immunization, or other reasons, or has not complied with conditional enrollment requirements.

E. "mailed" means deposited in the mail or delivered for transmission by any other usual means of communication with postage or cost of transmission provided for and addressed to the latest address shown by school records.

F. "school" means public school.

G. "school day" means each day of the school year during which the average daily membership of students is computed pursuant to the Public School Finance Act. [Sections 22-8-1 to 22-8-46, NMSA, 1978 Comp.].

H. "student" means a "qualified student" eligible to attend public school, as that term is defined in Section 22-8-2, NMSA, 1978 Comp.

III. *Policy*. From time to time it will be necessary to disenroll students because of invalid enrollment.

IV. *Limitation on Enrollment*. Where a student is found to have an invalid enrollment the student shall be disenrolled from school.

V. *Procedure*. Where the administrative authority has reason to believe a student is enrolled under an invalid enrollment the administrative authority shall take the following action.

A. *Preliminary Notice of Contemplated Action of Disenrollment*. The administrative authority shall give a Preliminary Notice of Contemplated Action of Disenrollment to the student, through his parent or guardian, of the contemplated disenrollment and the reasons therefore. The preliminary notice shall be in writing, and mailed to the student not later than ten (10) days before the Notice of Disenrollment is to be mailed.

The preliminary notice shall state that: (1) the student has a right to respond, either in writing or in person, to the administrative authority before the date of the contemplated action of disenrollment, and (2) the student may attempt to resolve the matter informally by presenting adequate evidence to the administrative authority to refute the alleged reasons for the contemplated action of disenrollment.

B. *Stay of Proceedings.* Where the question of the student's enrollment is under review by an administrative agency in the State of New Mexico or any court of competent jurisdiction, and written documentation has been filed with the administrative authority establishing the pendency of the action, all proceedings under this regulation shall be stayed pending final determination of the question by that agency or court.

C. *Notice of Disenrollment.* Where the student has not presented satisfactory evidence to cure the invalid enrollment and has been afforded notice as required by Section V A, the administrative authority shall give written notice to the student, through his parent or guardian, that the student will be disenrolled. The Notice of Disenrollment shall be mailed ten (10) school days after the mailing of the Preliminary Notice of Contemplated Action of Disenrollment.

The Notice of Disenrollment must include a copy of this rule and must advise the student, through his parent or guardian, of the following:

1. Subject to the procedure in Section V C (2), herein, if satisfactory evidence to refute the alleged reasons for the contemplated action of disenrollment is not submitted to the administrative authority within ten (10) school days from the date of mailing of the Notice of Disenrollment, the student will be disenrolled.
2. The student may, at any time within the ten (10) school days after the date of mailing of the Notice of Disenrollment, present the administrative authority with an oral or written request for a hearing on the matter.
    a. The hearing shall be held within five (5) school days after receipt of a request for hearing.
    b. The student may appear at the hearing, with or without counsel, to refute the alleged reasons for the disenrollment.
    c. The student may present witnesses or evidence at the hearing, as well as question any witnesses favoring disenrollment.
3. Within five (5) days after the hearing the hearing officer shall issue and mail to the student, through his parent or guardian, the decision setting forth his decision and the reasons therefore.
4. If the hearing officer decides in favor of the student, the matter shall be closed. If the hearing officer decides against the student, the student shall be disenrolled from school five (5) school days from the date of mailing of the decision.
5. If no request for a hearing is received within the time provided the student shall be permitted to re-enroll only when all legal requirements for enrollment are met.

D. *Hearing Officer.* The administrative authority may designate one or more of its staff to act as hearing officer for disenrollment matters; who, upon referral of the case from the administrative authority shall follow the procedures set forth herein to afford the student and his parent or guardian due process.

E. *Hearing Procedure.* The hearing shall be set within five (5) days after a written or oral request for hearing is received by the administrative authority.

1. The administrative authority shall conduct the hearing informally but with dignity, firmness and fairness appropriate to the importance of the proceedings.
2. A secretary to the administrative authority shall keep minutes of the proceedings but a verbatum transcript setting forth the substance of the evidence presented shall not be required.

3. The hearing shall be conducted to afford the student due process, and shall provide:
    a. an opportunity for the child and his parent or guardian to respond at the hearing;
    b. the right to present evidence;
    c. the right to confront adverse witnesses;
    d. the right of cross examination;
    e. the right to be represented by counsel;
    f. the right to have a decision based solely on the applicable legal rules and the evidence presented at the hearing.
4. Within five (5) school days after the hearing, the hearing officer shall prepare and mail to the student, through his parent or guardian, a written decision and the reasons therefore.

VI. *Repeal.* This regulation supercedes and repeals all other rules and regulations in conflict herewith.

Adopted by the State Board of Education August 26, 1976

HEALTH
ENVIRONMENT
STATE OF NEW MEXICO
Health Services Division

COMPULSORY IMMUNIZATION REGULATIONS

Immunizations Required

Authority for Regulation: This regulation has been promulgated pursuant to Sections 24-5-1 through 24-5-6 NMSA 1978, being laws 1959, Chapter 329, Sections 1 through 6, as amended. Enforcement of this regulation is the responsibility of the Health Services Division of the Health and Environment Department.

The following immunizations are required for all pupils of public, private or parochial elementary and secondary schools, as well as all those pupils in Early Childhood Education facilities under the New Mexico Department of Education, and all children in licensed preschool or child care centers, except for those children who have been legally exempted from these immunizations:

DIPHTHERIA, PERTUSSIS, TETANUS, POLIOMYELITIS, MEASLES AND RUBELLA

The manner and frequency of the administration of the required immunizations shall be prescribed by Schedule issued from time to time by the Director of the Health Services Division, Health and Environment Department.

Religious Exemption from School Immunization

Authority for Regulation: This regulation has been promulgated pursuant to Section 24-5-3 NMSA 1978, and the opinion of the Attorney General No. 75-69, issued December 8, 1975.

1. EXEMPTION BY MEMBERSHIP IN RECOGNIZED RELIGIOUS DENOMINATION: Any parent or guardian belonging to a recognized religious denomination whose religious teaching requires reliance upon prayer or spiritual means alone for healing and who seeks exemption from the compulsory student immunization requirements of Section 24-5-2 NMSA 1978 for their child shall present affidavits from an officer of the denomination stating that the parents or guardians are *bona fide* members of said recognized religious denomination and that the religious teaching of the denomination requires reliance upon prayer or spiritual means alone for healing. Upon filing such affidavit, the child is exempt from legal requirements of immunization for a period not to exceed nine (9) months on the basis of any one certificate.

2. EXEMPTION BY CERTIFICATION OF RELIGIOUS OBJECTION: A parent or guardian who cannot obtain an affidavit from an officer of a recognized religious denomination as described in Paragraph 1, hereof, but whose religious beliefs, held either individually or jointly with others, do not permit the administration of vaccine or other immunizing agents, may apply for an exemption from immunization by submitting a certificate of conscientious objection to immunization.

   2.1 OATH. The certificate must be signed in the presence of a notary public.

   2.2 CONDITIONAL ENROLLMENT. Upon presentation of a notarized certificate to the principal of the school to which a child seeks enrollment, the principal shall allow the child to be enrolled conditionally until such time as the certificate is either approved or disapproved by the Director of the Health Services Division.

   2.3 GROUNDS FOR DISAPPROVAL. The Director of the Health Services Division or his or her designee may disapprove a certificate for failure to fully complete it or for failure to allege beliefs and practices sufficient to warrant an exemption from immunization for religious reasons consistent with the legislative intent of Section 24-5-3, as explained in opinion of the Attorney General No. 75-69, dated December 8, 1975.

   2.4 ROLE OF SUPERINTENDENT. Every principal receiving a Certificate of Conscientious Objection to Immunization shall deliver the same to the Superintendent of schools for the district by which the Principal is employed within seven (7) days of the time the certificate has been received; the superintendent shall note on his or her records that a religious exemption has been claimed on behalf of each child so claiming and forward the original certificate to the Director of the Health Services Division within seven (7) days of the time it has been received from the school principal.

(OVER)

2.5 DUTIES OF STATE DIRECTOR. Within sixty (60) days of his or her receipt of a Certificate of Conscientious Objection to Immunization, the Director of the Health Services Division, or his or her designee shall, (i) determine whether the certificate has been duly completed and notarized; (ii) make or cause to be made such investigation as may be appropriate to ascertain that the exemption is a bona fide claim of religious beliefs and practices; (iii) advise in writing the parent or guardian of the subject child, and the superintendent of the school district in which the child's school is located, and the principal of the school at which the child has been conditionally enrolled that the claimed religious exemption has been approved or disapproved. In the case of disapproval of a claim to religious exemption, the Director of the Health Services Division or his or her designee shall state the reason or reasons therefore in the letter of notification.

2.6 RIGHT TO APPEAL. Every parent or guardian of a child whose claim on behalf of that child for religious exemption from the student immunization requirements is disapproved by the Director of the Health Services Division shall have the right to pursue an administrative appeal from such disapproval. The manner and method of administrative appeal shall be determined by the Secretary of the Health and Environment Department.

HEALTH AND ENVIRONMENT DEPARTMENT
STATE OF NEW MEXICO
Health Services Division

CERTIFICATE
of
CONSCIENTIOUS OBJECTION to IMMUNIZATION

PLEASE PRINT

School ______________________ Parent/Guardian ______________________
name *name*

Address ______________________ Address ______________________
street *street*

______________________ ______________________
city *zip* *city* *zip*

Principal/Headperson ______________________
name

DIRECTIONS:
Please complete the following, stating the religious foundation of your objection, giving your child's name, specifying your relationship to your child, and your address. Then, in the presence of a Notary Public, please sign and date the certificate and have it notarized.

The religious foundation of my objection to immunization is as follows:

....

....

....

....

....

....

In accordance therewith and with Section 24-5-3 NMSA 1978, I hereby certify that the administration of vaccine and other immunizing agents to my child ______________________, is contrary to my religious beliefs, held either individually or jointly with others, and I therefore request that my child be exempted from the school immunization requirements of Section 24-5-2 NMSA 1978.

I AM INFORMED OF AND I FULLY UNDERSTAND AND ACCEPT THE RISKS OF NON-IMMUNIZATION FOR MY CHILD. I swear that all the foregoing statements are true to the best of my information, knowledge and belief.

☐ Parent ☐ Guardian ______________________ ______________________
signature *date*

Subscribed and Sworn before me this ______ day of ______________, 19 ____.

____
Notary's Signature and Seal

My Commission Expires: ______________________

1912

HED/HSD 110 Revised 5/79

(OVER)

CERTIFICATE of CONSCIENTIOUS OBJECTION to IMMUNIZATION - Side two

RISKS OF NON-IMMUNIZATION

The process of routine immunization recommended by the Health Services Division, Health and Environment Department involves the administration (orally or by injection) of attenuated (weakened) viruses, dead bacteria or bacterial products which stimulate the body's own natural defenses against these viruses, bacteria, and bacterial products. Essentially, the process gives a person a mild form of the disease or introduces the body's immune system to non-harmful parts of bacteria so that the person's system can recognize these as "Intruding Bodies" and form "Antibodies". These antibodies protect the person upon exposure to the natural, unweakened germs. Vaccines are not useful in treating illness. Their usefulness is in preventing illness.

The Risks of Non-Immunization in New Mexico are:

POLIOMYELITIS (Paralytic Polio)

Thanks to a widespread and successful immunization campaign begun in late 1955 very few cases of this disease occur annually in the United States. The risk of an unimmunized child contracting polio is, however, greater in New Mexico than in many other areas of the United States due to proximity to Mexico where polio still exists.

If a significant number of children in a school or other institution are unimmunized, then an outbreak can more readily occur. The latest school polio outbreak occured in Connecticut in 1972. Eleven unimmunized children in that instance came down with the paralytic disease.

Approximately 10% of those children who contract paralytic polio will die.

MEASLES

Measles is the most serious of the routine childhood diseases. It almost always causes a high fever (103° – 105°) and a rash and it usually lasts approximately 10 days. Measles may lead to pneumonia, serious ear infections, deafness, convulsions, or encephalitis (inflamation of the brain). Brain disorders occur in approximately 1 out of every 1000 children who get the disease. Of those children who develop a brain disorder from measles, approximately 1 in 10 will die and two of every ten will have mental retardation. In a recent study of reported deaths in New Mexico, measles was found to be the fourth most common cause of death attributable to the communicable diseases. New Mexico is among the six states with the highest fatality rate for measles cases in the nation. Measles is of little concern, however, if a child is immunized.

RUBELLA

Rubella (German Measles) is a mild disease of little serious risk to children. The main risk is to non-immune women of childbearing age if they are infected just before or during the first three months of pregnancy. Infection in these pregnant women may result in miscarriage, stillbirth, or multiple birth defects including blindness and heart disease. The reasons children should be immunized are twofold:

1. To establish immunity in girls at a nonfertile, young age; and
2. To provide immunity to young boys and girls in order to prevent their spreading the disease to adult women who may be pregnant and susceptible to rubella.

The current risk of an unimmunized child getting rubella and passing it to a pregnant woman is not known. What is known is that the child of a pregnancy during which rubella is contracted has a 15-35% chance of being mentally retarded, of having heart disease or of being blind. The costs of care during the lifetime of one such case is approximately $250,000. Programs of immunization against rubella have markedly reduced congenital deformities and defects in newborns caused by the virus.

DIPHTHERIA

This disease currently has a death rate of 10% (one case in 10 will die). There has been one epidemic of diphtheria in New Mexico during the past 5 years and a total of 83 cases have been reported from 1972-1976.

The chances of becoming seriously ill if unimmunized is 20 times greater than if immunized.

The chances of dying from a case of diphtheria if unimmunized is 5 times greater than if immunized.

TETANUS (Lockjaw)

This rare disease involves the release of a powerful poison caused by certain germs growing in dirty wounds. Tetanus has a 35-70% death rate in the U.S. In New Mexico this disease has been 100% fatal in the cases reported during the last 10 years. Fortunately, the disease does not occur often due to improved medical treatment of wounds.

There is a much greater risk of a newborn acquiring tetanus when an unimmunized mother gives birth at home.

PERTUSSIS (Whooping Cough)

This disease involves infection of the breathing tubes of the lung (Trachea and Bronchi) and is especially dangerous to young children. Approximately 72% of the deaths due to pertussis and its complications occur in children under 1 year of age. Immunization protects against death and serious illness. If immunized children get the disease, it is usually milder than in children who are not immunized.

Since pertussis vaccine has been available there has been a sevenfold decrease in the number of deaths due to pertussis.

STATE OF NEW MEXICO
ENVIRONMENT
Health Services Division

ROSTER OF STUDENTS WITH IMMUNIZATIONS NOT CURRENT

SCHOOL DISTRICT	SCHOOL	SCHOOL YEAR	DATE SUBMITTED
CITY	COUNTY	PRINCIPAL	SUPERINTENDENT

Number of Students Enrolled By Grade (1)	Number of Students CURRENT*			Number of Students EXEMPT		Number of Students NOT CURRENT (7)
	Up-to-Date (2)	In Process (3)	Transfer (within 6 wks) (4)	Religious/ Conscientious (5)	Medical (6)	
K						
1						
2						
3						
4						
5						
6						
7						
8						
9						
10						
11						
12						
Other:						
TOTAL						

(7) **NOT-CURRENT IMMUNIZATIONS STATUS** (Check immunizations the student needs to become current)

GRADE	NAME OF STUDENT	DPT/TD						POLIO						MEASLES	RUBELLA
		1	2	3	4	5	6	1	2	3	4	5	6		

**Recommended immunization schedule of Health Services Division, New Mexico Health and Environment Department.*

SCHOOL NURSE SIGNATURE

15170

INSTRUCTIONS FOR PREPARATION OF ROSTER OF STUDENTS WITH IMMUNIZATIONS NOT CURRENT

The completed form must be filled out for each individual school and forwarded to the Immunization Program Manager, Health Services Division, NM Health and Environment Department, P.O. Box 968, Santa Fe, New Mexico 87504-0968. The form must be received by the Health Services Division no later then November 15th of the current school year.

1. Enter on the top portion of the form the following:
   a. The name of the school district.
   b. The name of the school.
   c. The current school year.
   d. The date the form is submitted.
   e. The city in which the school is located.
   f. The county in which the school is located.
   g. The principal of the school.
   h. The superintendent of the school district.
2. The following information must be filled out for **each grade** in the school as listed on the form and entered in the appropriate box.

   Number of Students Enrolled

   Column (1): The number of students enrolled in kindergarten, first grade, second grade, etc.
   Column 1 = Column 2 + 3 + 4 + 5 + 6 + 7

   Number of Students Current

   Column (2): The number of students that are current in kindergarten, first grade, second grade, etc. This column would include only those students completely up-to-date with their immunizations.

   Column (3): The number of students who are in the **approved** category of "in process". A student is considered "in process" of obtaining complete and up-to-date immunizations when s/he is in compliance with the Health Services Division "Guidelines for Immunization of Schoolchildren in New Mexico."

   Column (4): The number of transfer students who are conditionally enrolled for a period not to exceed six weeks during which time they must 1) obtain proof to demonstrate current immunization status, or 2) begin and establish enrollability as "in process" of becoming currently immunized, or 3) apply for a medical or a religious exemption from compulsory immunization.

   Number of Students Exempt

   Column (5): The number of students who are excused as the result of an approved religious exemption in kindergarten, first grade, second grade, etc.

   Column (6): The number of students who are excused as the result of a physician's certificate of medical exemption in kindergarten, first grade, etc.

   Number of Students Not Current

   Column (7): The number of students who are neither current nor exempt in kindergarten, first grade, second grade, etc.

   The totals of each column should then be entered in the box entitled Total.
3. The following information is required for each student who is in the **Not Current** column (7):
   a. The grade of the student
   b. The name of the student
   c. The immunization(s) needed to become current as indicated by a check in the appropriate column(s) for DPT/Td, Polio, Measles or Rubella.
4. The form must be signed by the school nurse responsible for its completion.

ARTICLE 5

Immunization

Sec.
24-5-1. Immunization regulations.
24-5-2. Unlawful to enroll in school unimmunized; unlawful to refuse to permit immunization.

Sec.
24-5-3. Exemption from immunization.
24-5-4. Superintendent; duty to report.
24-5-5. Who may immunize; who must pay.
24-5-6. Penalty.

24-5-1. Immunization regulations.

The health services division of the health and environment department shall, after consultation with the state board of education, promulgate rules and regulations governing the immunization against diseases deemed to be dangerous to the public health, to be required of children attending public, private or parochial schools in the state. The immunizations required, and the manner and frequency of their administration, shall conform to recognized standard medical practice in the state. The health services division of the health and environment department shall supervise and secure the enforcement of the required immunization program.

History: 1953 Comp., § 12-3-4.1, enacted by Laws 1959, ch. 329, § 1; 1977, ch. 253, § 20.

Am. Jur. 2d, A.L.R. and C.J.S. references. — 39 Am. Jur. 2d Health § 27; 68 Am. Jur. 2d Schools §§ 277 to 280.

Power of municipal or school authorities to prescribe vaccination or other health measure as condition of school attendance, 93 A.L.R. 1413.

39A C.J.S. Health and Environment §§ 18, 22; 79 C.J.S. Schools and School Districts §§ 452, 453.

24-5-2. Unlawful to enroll in school unimmunized; unlawful to refuse to permit immunization.

It is unlawful for any student to enroll in school unless he has been immunized, as required under the rules and regulations of the health services division of the health and environment department, and can provide satisfactory evidence of such immunization. Provided that, if he produces satisfactory evidence of having begun the process of immunization, he may enroll and attend school as long as the immunization process is being accomplished in the prescribed manner. It is unlawful for any parent to refuse or neglect to have his child immunized, as required by this section, unless the child is properly exempted.

History: 1953 Comp., § 12-3-4.2, enacted by Laws 1959, ch. 329, § 2; 1975, ch. 25, § 1; 1977, ch. 253, § 21.

24-5-3. Exemption from immunization.

A. Any minor child through his parent or guardian may file with the health authority charged with the duty of enforcing the immunization laws:

(1) a certificate of a duly licensed physician stating that the physical condition of the child is such that immunization would seriously endanger the life or health of the child; or

(2) affidavits or written affirmation from an officer of a recognized religious denomination that such child's parents or guardians are bona fide members of a denomination whose religious teaching requires reliance upon prayer or spiritual means alone for healing; or

(3) affidavits or written affirmation from his parent or legal guardian that his religious beliefs, held either individually or jointly with others, do not permit the administration of vaccine or other immunizing agent.

B. Upon filing and approval of such certificate, affidavits or affirmation, the child is exempt from the legal requirement of immunization for a period not to exceed nine months on the basis of any one certificate, affidavits or affirmation.

History: 1953 Comp., § 12-3-4.3, enacted by Laws 1959, ch. 329, § 3; 1979, ch. 42, § 1.

Section is controlling as to children attending public, private or parochial schools. 1961-62 Op. Att'y Gen. No. 62-5.

Chiropractors do not qualify as physicians for the purposes intended by this section. 1959-60 Op. Att'y Gen. No. 59-96.

24-5-4. Superintendent; duty to report.

It is the duty of each school superintendent, whether of a public, private or parochial school, to cause to be prepared a record showing the required immunization status of every child enrolled in or attending a school under his jurisdiction. These records must be kept current and available to the public health authorities. The name of any parent or guardian who neglects or refuses to permit his child to be immunized against diseases as required by rules and regulations promulgated hereunder shall be reported by the school superintendent to the director of the health services division of the health and environment department.

History: 1953 Comp., § 12-3-4.4, enacted by Laws 1959, ch. 329, § 4; 1975, ch. 25, § 2; 1977, ch. 253, § 22.

Applicability. — Laws 1975, ch. 25, § 3, provides that the provisions of the act apply to children who may enroll, register or attend school in the school year beginning in the fall of 1975.

24-5-5. Who may immunize; who must pay.

The immunization required may be done by any licensed physician or by someone under his direction. If the parents are unable to pay, the immunization shall be provided by the health services division of the health and environment department. No public health employee may receive any fee for immunization service if the service is compensated for by the health services division. Local school boards may contribute toward the cost of materials and supplies for immunizations.

History: 1953 Comp., § 12-3-4.5, enacted by Laws 1959, ch. 329, § 5; 1977, ch. 253, § 23.

24-5-6. Penalty.

Violation of any provisions relating to the immunization of school children is a misdemeanor.

History: 1953 Comp., § 12-3-4.6, enacted by Laws 1959, ch. 329, § 6.

NOTES:

NEW MEXICO HEALTH and ENVIRONMENT DEPARTMENT

NM Health and Environment Department
Health Services Division
GUIDELINES FOR IMMUNIZATION OF SCHOOLCHILDREN IN NEW MEXICO
MARCH 1984

According to New Mexico's school immunization law, the HED Health Services Division has the responsibility of promulgating schedules which define immunization requirements for schoolchildren.

In the past, the use of several schedules has resulted in some confusion. This schedule is the single document needed to determine if a schoolchild needs any doses of vaccine, and if so, according to what schedule these doses should be given. The latter is important since it defines "in process" status; in other words, a child who needs two doses of a vaccine in order to be complete can usually receive the first dose now, but the second dose would be given several months later. If the second dose is not administered within the designated time-frame, the child has fallen out of compliance and corrective steps must be taken.

Use of the Schedule: To use this schedule, two facts must be known: the age of the child and the number of doses of the particular vaccine which have already been adminstered.

VACCINE	AGE OF CHILD NOW	NO. OF DOSES GIVEN IN THE PAST	NO. OF DOSES STILL NEEDED	SCHEDULE OF IMMUNIZATION
DPT	3-6 years (up to 7th birthday)	0	4[a]	Now, 2 mo. later, 2 mo. later. 6-12 mo. later or preschool, and[b]
		1	3[a]	Now[c], 2 mo. later, 6-12 mo. later or preschool, and[b]
		2	2[a]	Now[c], 6-12 mo. later or preschool, and[b]
		3	1[a]	6-12 mo. after last dose or preschool, and[b]
		4+	0[a]	[b]
Td	7+ years (7th birthday and older)	0	3	Now, 1-2 mo. later, 6-12 mo. later, and[d]
		1	2	Now[c], 6-12 mo. later, and[d]
		2	1	6-12 mo. after last dose (in some cases this means now), and[d]
		3+	0	Td booster every 10 years after last dose
POLIO (TOPV)	3-6 years (up to 7th birthday)	0	3[a]	Now, 2 mo. later, 6-12 mo. later or preschool
		1	2[a]	Now[c], 6-12 mo. later or preschool
		2	1[a]	6-12 mo. after last dose (in some cases this means now) or preschool
		3+	0[a]	
POLIO (TOPV)	7-17 years (7th birthday up to 18th)	0	3	Now, 2 mo. later, 6-12 mo. later
		1	2	Now[c], 6-12 mo. later
		2	1	6-12 mo. after last dose (in some cases this means now)
		3+	0	
MEASLES	15 months through high school	0	1	Now
		1	0	EXCEPTION: If any of the following apply, a re-vaccination is required: 1) Immunized before 12 mos. of age 2) If immunized before 1968[e]
RUBELLA	15 months through high school	0	1	Now- EXCEPTION: Written documentation of laboratory testing declaring immunity to rubella
		1	0	EXCEPTION: If immunized before 12 mos. of age, a re-vaccination is required

---

[a] At least 1 dose must be given after the 4th birthday; if not, an additional dose must be given after the 4th birthday.

[b] Td at age 14-16 years and every 10 years thereafter.

[c] This dose must be given at least 2 months after the last dose.

[d] Td booster every 10 years after receiving the 3rd dose.

[e] Specific guidelines for re-vaccination are available from the Epidemiology Office at 827-3201.

APPENDIX B

JOB DESCRIPTIONS

SCHOOL NURSING COORDINATOR JOB DESCRIPTION
1985

TITLE: SCHOOL NURSING COORDINATOR

QUALIFICATIONS:

1. Valid certificate as a school nurse as established by the New Mexico State Department of Education.
2. Current professional license to practice as a Registered Nurse, issued by the New Mexico Board of Nursing.
3. Bachelor's degree in nursing, public health, education, or a closely related field.
4. A minimum of three years' experience in public school nursing.
5. Knowledge of the laws, regulations, and policies relating to school and public health in New Mexico.

REPORTS TO: Superintendent or designee.

JOB GOAL: To administer the nursing services for the promotion of health and safety to students and staff throughout the school system toward the accomplishment of educational objectives.

PERFORMANCE RESPONSIBILITIES:

1. Plan, implement, and evaluate school nursing programs with staff participation.
2. Participate in the formulation and interpretation of policies pertaining to school health.
3. Coordinate school health services with those of local and state agencies.
4. Perform the personnel functions of selection, orientation, training, assignment, evaluation, and staff development of school nurses.
5. Participate in planning health service units for new or remodeled facilities.
6. Maintain liaison and cooperate with individuals and community agencies that provide health related or supportive services contributory to school health.
7. Maintain current manuals for school nurses with staff participation.

8. Arrange for ordering, care, and distribution of supplies and equipment for nursing service units.

9. Assemble data and prepare reports of the school health activities for distribution to the Superintendent and official and voluntary agencies as appropriate.

10. Assist and help prepare the departmental budget and administer the allocated funds.

11. Perform other related tasks as requested by the Superintendent or designee.

TERMS OF EMPLOYMENT: As determined by the Board of Education.

EVALUATION: Performance of this job will be evaluated annually in accordance with the provisions of the Board/Superintendent's policy on evaluation of employees.

SCHOOL NURSE JOB DESCRIPTION
1985

TITLE: SCHOOL NURSE

QUALIFICATIONS:

1. Current professional New Mexico license to practice as a Registered Nurse, issued by the New Mexico Board of Nursing.
2. Valid certificate as a school nurse as established by the New Mexico Department of Education.

REPORTS TO: School Principal (and School Nursing Coordinator, if applicable).

JOB GOAL: To utilize those principles of health and education which are basic in working with the child in his/her total environment of home, school, and community, so that a state of optimum health may result.

PERFORMANCE RESPONSIBILITIES:

1. Helps to develop and implement school health policies and procedures of the local school district.
2. Identifies health problems including social, psychological, and economic factors that interfere with learning, through screening procedures, assessment, and evaluation of the student.
3. Makes appropriate referrals based on data obtained from assessment and screening procedures.
4. Makes home visits when the need arises.
5. Maintains student health and immunization records to include day, month, year, and appropriate follow-up.
6. Assist administration in arranging for emergency care and first aid for all students and employees.
7. Implements policies and procedures regarding control of communicable diseases in accordance with regulations of the State of New Mexico Health and Environment Department.
8. Authorizes exclusion and readmission of students in connection with infectious, contagious, and nuisance diseases.

School Nurse, Continued

9. Serves as a consultant and resource person to staff, parents, and students in identifying community resources.

10. Participates with school staff in developing and implementing a total school health program which includes health promotion activities.

11. Advises teachers and consults with parents on health matters, particularly regarding assessments and screening results for student health defects.

12. Serves on and/or attends committee meetings and conferences regarding health services and curriculum.

13. Participates in in-service training programs, workshops, and continuing education to maintain professional status. Must maintain current CPR certification.

14. Serves as a consultant in matters of school health, safety, health education, and sanitary conditions.

15. Participates in case conferences and support items.

16. Arranges for transportation in emergency situations, if needed.

17. Assists Principal and Nursing Coordinator in performance of any other health-related assignments.

SCHOOL/FAMILY/PEDIATRIC NURSE PRACTITIONER JOB DESCRIPTION
1985

TITLE: SCHOOL NURSE, FAMILY, PEDIATRIC NURSE PRACTITIONER IN A PUBLIC SCHOOL SYSTEM

QUALIFICATIONS:

1. Current professional license to practice as a Registered Nurse, issued by the New Mexico Board of Nursing.

2. Valid certificate as a school nurse as established by the New Mexico Department of Education.

3. Bachelor of Science Degree in nursing desired but not required.

4. Knowledge of principle practices and techniques of professional nursing as it relates to public school health services.

5. Certification as a Nurse Practitioner, having successfully completed a formally organized program at an institution of higher education as preparation for the provision of delivery of primary health care.

REPORTS TO: Director of Instruction and protocol of physician. Consult with State Supervisor of School Nurses.

JOB GOAL: To achieve, maintain, and restore the health of the children and youth in the school setting, recognizing that many factors influence the health and welfare of children. The nurse practitioner must work not only with the child and school personnel, but also with the family and community in the roles of manager, deliverer of health services advocate, counselor, educator, and evaluator.

PERFORMANCE RESPONSIBILITIES:

1. Formulates objectives of the school health program within the framework of the school philosophy.

2. Performs all responsibilities of a registered nurse.

3. Personal accountability for decisions of change, initiation, and treatment by the nurse practitioner to others and those delegated by him/her by the legally authorized physician or dentist.

4. Performs physical examinations.
5. Collects, performs, and interprets lab data, initiating request for essential laboratory procedures and x-rays for a student under the physician's supervision or understanding orders.
6. Screens students having problems requiring differential medical diagnosis and therapy.
7. Determines and reports the patient's degree of wellness or illness (physical or emotional).
8. Indicates changes or modifies treatment according to standing orders or in collaboration with the physician in light of the student's condition within the established plan of medical and nursing protocols.
9. Supervises family health, which includes well-child care, immunizations, and prevention programs.
10. Performs health teaching, counseling, and guidance.
11. Promotes a positive outreach approach for pregnant teenagers and adolescent parents.
12. Serves as a liaison between the school district and community health agencies and providers.
13. Plans and institutes health care programs in the community with other health care professionals and the public.

THE NURSE PRACTITIONER AS AN EDUCATOR:

1. Correlates health approval and screening procedures with the health education curriculum.
2. Encourages teachers to present topics of interest and concern by providing stimulation and up-to-date materials.
3. Collaborates with teachers in providing educational activities in areas such as: drug and alcohol abuse, suicide, personal and family living, nutrition, safety methods, and health and sexuality classes.
4. Provides in-service education in the classroom on an ongoing basis.
5. Participates in health curriculum with teachers and other school personnel.

TERMS OF EMPLOYMENT: Benefits, working hours as applicable to teachers and directed by the Board of Education.

EVALUATION: In accordance with the Board of Education policy for evaluation of other employees.

SCHOOL HEALTH AIDE JOB DESCRIPTION
1985

TITLE: SCHOOL HEALTH AIDE

QUALIFICATIONS:

1. High school graduate or equivalent.
2. Interest in working with children.
3. Stability, maturity, and ability to recognize limitations and to accept and utilize supervision and consultation.
4. Good command of the English language; bilingual desired.
5. Current New Mexico driver's license.
6. Current Standard Red Cross first-aid certificate and CPR certificate (can be obtained on the job).
7. Knowledge of clerical work, including typing and office procedures.
8. Respect for confidential information.
9. Ability to establish and maintain sound working relationships with school personnel and community.

REPORTS TO: Principal and School Nurse.

JOB GOALS:

1. To release school nurses from nonprofessional school health functions so that they may have more time and opportunities to use their professional nursing skills in the school health program.

PERFORMANCE RESPONSIBILITIES:

1. Assists in maintaining school health record system.
2. Administers first aid for injuries and illnesses to students as provided for by school policy.
3. Assists with screening tests.
4. Makes appropriate referrals to the school nurse for follow-up of pupil health problems.
5. Carries out routine office procedures.
6. Assists with immunization records and recording on health records.

7. Sends home routine referrals for medical and dental examinations for selected groups of pupils.

8. Keeps reports of own activities.

9. Keeps first-aid kits stocked.

10. Maintains bulletin boards in health office and display case.

11. Performs any health-related task assigned by the school nurse.

12. Tabulates reports for the school nurse (monthly and annual).

EVALUATION: Annually, by school nurse or Head Nurse in accordance with Board of Education policy.

IN-SERVICE TRAINING: By school nurses involved where employed, and should include: methods of vision and hearing screening; role of the school nurse; records and forms systems; school health policies of the district, including emergency care and communicable disease control procedures; school health laws; general office procedures and routines; and keeping of activity reports and daily logs. Routine first-aid steps.

APPENDIX C

CONTACT PERSONNEL

SOCIAL SERVICES DIVISION

New Mexico Field Services Bureau: 827-4256
Bernalillo County Emergency Response Team: 1-800-348-3456

County	Location	Phone
DISTRICT I	P.E.R.A. Building, Room 519, Santa Fe	827-4268
Colfax	120 South Third, Raton	455-3695
Guadalupe	330 South Fifth, Santa Rosa	472-3450
Harding	(Contact Colfax office)	455-3695
Los Alamos	901 Trinity Drive, Los Alamos	662-4551
Mora	Highway 3 & Road to Mora School, Mora	387-2704
Rio Arriba	Taos Highway, Espanola	753-7191
Santa Fe	La Fontana Bldg., 3157 Cerrillos Rd., Santa Fe	827-7680
San Miguel	3113 Hot Springs Blvd., Las Vegas	425-9335
Taos	Cruz Alta & Gusdorf, Taos	758-8871
Union	403 Main Street, Clayton	374-9862
DISTRICT II		
Bernalillo	2340 Menaul NE, Albuquerque	841-6100
Torrance	Community Hall, Estancia	384-2222
Win/Sau	1023 Tijeras NW, Albuquerque	841-8668
DISTRICT III	P.O. Box 220, Los Lunas	865-4634
Cibola	825 East Santa Fe, Grants	285-6673
Dona Ana	435 North Main, Las Cruces	524-2806
Grant	Yankee & Black, Silver City	538-2945
Hidalgo	334 East Railroad, Lordsburg	542-3562
Luna	120 East Poplar, Deming	546-2797
McKinley	2907 East Aztec, Gallup	863-9556
N. Catron	(Hwy. 60 & Horse Springs: contact Socorro County)	835-2716
Sandoval	900 Camino del Pueblo, Bernalillo	867-2373
San Juan	101 West Animas, Farmington	327-5316
Sierra	122 Broadway, Truth or Consequences	894-3414
S. Catron	(Luna, Aragon & L. Area: contact Grant County)	538-2945
Socorro	100 6th Street SE, Socorro	835-2716
Valencia	303 Luna Avenue SE, Los Lunas	865-4634
DISTRICT IV		
Chaves	101 South Main, Roswell	622-9882
Curry	818 West 6th Street, Clovis	762-7721
De Baca	(Contact Curry County)	762-7721
Eddy	1105 West Mermod, Carlsbad	887-3576
Eddy	601 Mahone, Artesia	748-1221
Lea	901 East Bender, Hobbs	393-9122
Lea	201 East Washington, Lovington	396-4012
Lincoln	West Gate Shopping Center, Ruidoso	257-9217
Otero	411 10th Street, Alamogordo	437-0030
Quay	1310 East Main, Tucumcari	461-0110
Roosevelt	413 East South Main, Portales	346-6688

HEALTH AND ENVIRONMENT DEPARTMENT

Field Operations Bureau

Chief	Roy McKeag, MPH	827-2331
Chief Nurse	Lee Bartol, RN	827-2333
District One	District Health Officer	327-4461
District Two	District Health Officer	827-9660
District Three	District Health Officer	841-4100
District Four	District Health Officer	763-5583
District Five	District Health Officer	526-6617
District Six	District Manager	622-2000

Immunization Specialist

Director	827-2368

Crippled Children's Services

Director	827-2542

State Epidemiologist

Dr. Harry Hull	827-3201

OTHER IMPORTANT NUMBERS

Orthopedic Hospital

Carrie Tingley Hospital	842-9121
Toll Free Number	1-800-472-3235

State Department of Education

School Nurse Supervisor	827-6646

New Mexico Board of Nursing

Executive Director	841-4621

New Mexico Poison Control Center

Statewide Toll-Free Number	1-800-432-6866
Albuquerque Number	843-2551

APPENDIX D

SAMPLES/INFORMATION

NEW MEXICO CERTIFICATION REQUIREMENTS
FOR
SCHOOL NURSES

An individual working in the capacity of School Nurse in any of the public schools in the State of New Mexico is required to hold a School Nurse Certificate. All School Nurse Certificates are issued by the Division of Certification, New Mexico State Department of Education, Education Building, Santa Fe, New Mexico 87501.

GENERAL PROCEDURES: For ALL applicants for School Nurse Certificate under any plan.

1. Application form must be completed and returned to the Division of Certification.
2. The following must be sent to the Division of Certification, New Mexico State Department of Education, Education Building, Santa Fe, New Mexico 87501.
    a. Photocopy of current New Mexico nursing license.
    b. Official transcripts from college and/or nursing school.
    c. For certification under Plan III for Five-Year Certificate or for Provisional Certificate *only* – Experience or orientation verification.

Procedure:

Four-Week Orientation Program
To Meet School Nurse Certification Requirements

PROCEDURE FOR FULFILLING REQUIREMENTS FOR NEW MEXICO SCHOOL NURSE CERTIFICATION THROUGH FOUR-WEEK ORIENTATION IN A SELECTED SCHOOL NURSING SERVICE

A. A nurse wishing to qualify for school nurse certification via the orientation plan should:

1. Check list of certification requirements to be sure all others have been met.

2. Have assurance of employment in a school system in the state pending completion of certification requirements.

3. Select the orientation center on the basis of criteria given below.

4. Determine if the school system selected can accept her for orientation at the time desired.

5. After completing Steps 3 and 4 above, send the completed application form (attached) to the superintendent of schools in the system where orientation program is to be obtained.

6. Arrange details of program directly with supervising nurse.

7. Be sure supervising nurse has *three* report forms (attached); one to be sent to the State Department of Education at the completion of the four weeks, one to be retained by the nurse and the third to be available as a work sheet.

B. Criteria for a school nurse orientation center are as follows:

1. There must be at least three full-time nurses employed who hold five-year professional school nurse certificates.

2. The nurse supervising the orientation program must have been employed in the school system for a period of at least two years.

NOTE:

The nurse may be paid by the employing school during the orientation period if the employing Board of Education wishes to do so.

Orientation may be obtained in the employing school system if the above criteria for an orientation center are met by that system.

ONE YEAR PROVISIONAL SCHOOL NURSE CERTIFICATE

There are two plans under which an applicant can certify for the one (1) year Provisional Certificate.

PLAN I

One must meet the following requirements:

A. A current professional nursing license in New Mexico obtained from the New Mexico Board of Nursing, 505 Marquette N.W., Albuquerque, New Mexico 87103.

B. Graduate of a three year diploma program in nursing.

C. Six (6) semester hours of college credit (beyond credit applied to the basic nursing program) in areas applicable toward procuring a degree.

D. Any one of the following:

1. Four weeks supervised orientation to school nursing in New Mexico, or
2. Eight weeks supervised public health nursing experience, or
3. One year employment experience in school nursing, or
4. One year employment experience in generalized public health nursing.

PLAN II

One must meet the following requirements:

A. Current professional nursing license in New Mexico obtained from the New Mexico Board of Nursing, 505 Marquette N.W., Albuquerque, New Mexico 87103.

B. Graduate of a two (2) year nursing program culminating in Associate of Arts degree, plus one calendar year of graduate registered nurse experience in any field of nursing.

C. Any one of the following:

1. Four weeks supervised orientation to school nursing in New Mexico, or
2. Eight weeks supervised public health nursing experience, or
3. One year employment experience in school nursing, or
4. One year employment experience in generalized public health nursing.

RENEWAL

The one year Provisional School Nurse Certificate will be renewable for not more than five (5) times. After five renewals, the applicant should be eligible for a five year Professional Certificate. The holder of the one year Provisional Certificate must earn six (6) semester hours of credit each year in areas applicable toward procuring a degree.

FIVE YEAR PROFESSIONAL SCHOOL NURSE CERTIFICATE

There are three plans under which an applicant can certify for the five (5) year Professional Certificate.

PLAN I

One must meet the following requirements:

A. A current professional nursing license in New Mexico obtained from the New Mexico Board of Nursing, 505 Marquette N.W., Albuquerque, New Mexico 87103.

B. A Bachelor's degree with a major in nursing from a University, accredited by the National League of Nursing at the time the applicant graduated.

PLAN II

One must meet the following requirements:

A. A current professional nursing license in New Mexico obtained from the New Mexico Board of Nursing, 505 Marquette N.W., Albuquerque, New Mexico 87103.

B. A Bachelor's degree with a major in Education, Sociology, Home Economics, Health Education, or other related areas.

PLAN III

One must meet the following requirements:

A. A current professional nursing license in New Mexico obtained from the New Mexico Board of Nursing, 505 Marquette N.W., Albuquerque, New Mexico 87103.

B. Completion of a three year diploma program in nursing.

C. Completion of thirty semester hours (beyond credit applied to the basic nursing program) in subject areas applicable toward the procurement of a degree.

D. Any one of the following:

   1. Four weeks supervised orientation to school nursing in New Mexico, or
   2. Eight weeks supervised public health nursing experience, or
   3. One year employment experience in school nursing, or
   4. One year employment experience in generalized public health nursing.

RENEWAL

The five (5) year Professional School Nurse Certificate will be renewable for five (5) years at a time, provided the holder earns eight (8) semester hours of credit in areas toward procuring a degree; the credit to be approved in advance by the superintendent.

CONTINUING TEN YEAR PROFESSIONAL SCHOOL NURSE CERTIFICATE

One must meet the following requirements:

1. Eligible for the five year School Nurse Certificate.
2. Master's degree or thirty (30) semester hours of GRADUATE work from a regionally accredited college or university.
3. Verification by employer of three years of school nursing experience in New Mexico achieved during the five year period immediately preceding the date of application for the certificate.

RENEWAL

The ten year Professional School Nurse Certificate is renewable for ten (10) years at a time upon:

1. Verification by the employer of five (5) years successful school nursing experience in New Mexico during the life of the certificate.
2. Verification by the employer of professional growth on the part of the school nurse.

Approved by the New Mexico State Board of Education on March 10, 1971.

NEW MEXICO STATE DEPARTMENT OF EDUCATION

CERTIFICATION RENEWAL CREDIT FOR IN-SERVICE WORKSHOPS

Participant's Name (as certified): ______________________________

Certification File Number: ______________________________

Workshop Topic: ______________________________

Subject Area: ______________________________

School District: ______________________________

Total Number of Clock Hours Involved (Must total at least 16): ______________________________

Date Workshop Was Completed: ______________________________

Contact Person or Workshop Instructor's Signature: ______________________________

The above In-service Renewal Credit is approved by the employing school district.

____
Signature
Local Superintendent or Designee

ACTIVITIES SCHEDULE/TABLE

I. Every Month

On an ongoing basis, the following will be done:

A. Stock first-aid supplies in assigned schools.

B. Administer first aid as needed.

C. Administer vision and hearing tests and provide any other nursing service assistance requested for students referred to Special Education.

D. Act on referrals from teachers, parents, principals, counselors, or other school personnel regarding health-related problems.

E. Follow up on measures recommended after action is taken on referrals regarding health-related problems.

F. Provide supplies for the fluoride mouth rinse program in each grade school.

G. Provide instruction and materials to teachers as needed for them to teach CPR at the secondary-school level.

II. August and September

A. Put student health cards into order of new school year by grade and teacher in the elementary schools and by grade only in the secondary schools. Make health cards for kindergarten students.

B. Immunizations:

1. Record immunizations received by students during the summer.
2. Check immunization status of every student.
3. Send notices to parents of those students who need immunization.

C. Screening program of vision, hearing, tymponameter, and scoliosis, as scheduled.

Activities Schedule/Table, Continued

III. October

A. Continue screening program.

B. Continue work on immunizations.

IV. November

A. Prepare and submit the State Report on Immunizations for each school as required by law.

B. Recheck those students who failed any aspect of the screening program with priority given to those who indicate the greatest degree of problem.

C. Refer those students who indicate problems, after rechecking, to appropriate medical or other health care providers.

V. December

A. Finish rechecking and referring those students who indicate problems during the screening program.

B. Begin sex education programs at the elementary and junior high levels.

VI. January

A. Follow up on those students referred as a result of the screening program.

B. Finish sex education programs at the elementary and junior high school levels.

C. Begin, and continue to provide for the remainder of the school year, an acne control program to those students who volunteer to participate.

D. Begin, and continue to provide for the remainder of the school year, a weight control program for those students who wish to participate.

Activities Schedule/Table, Continued

VII. February

A. Continue follow up on those students referred as a result of the screening program.

B. Provide dental instruction kits as provided by the Crest Company to each of the third graders in the district.

C. Begin a sex education program at the high school level.

VIII. March

A. Recheck and refer as needed those students being followed for possible scoliosis.

B. Begin checking immunization status of each student and send notices to those who need immunizations before the school year ends.

C. Finish the sex education program at the high school level.

IX. April

A. Finish scoliosis rechecks and referrals.

B. Finish sending immunization notices to those who need immunizations before the school year ends.

X. May

A. Assist with kindergarten pre-registration.

B. Send immunization notices to those who need immunizations over the summer.

C. Provide first aid for track and field day at each elementary school.

D. Prepare and submit School Nurse Report to the State Department of Education.

E. Prepare inventories.

NURSING SERVICES ACTIVITY TABLE

Fall Registration

- Place nurse's emergency card with registration materials.
- Review immunization protocol/immunization records.
- Stock health room (make ice).

August

- Immunization process, PRN.
- First aid, PRN.
- Handicap card update, PRN.
  Review all cards. "Stat" report to faculty regarding high-risk students; diabetes, epilepsy, allergies.
- Record keeping, PRN.
  Keep accurate log of injuries, illnesses, medication administration.
- Nurse's presentation.
  Schedule agenda time at first faculty meeting to describe nursing program.
- Prepare forms.
  Daily log, student passes, class lists.
- Schedule vision and hearing screening.
  Screen all special education students early.

September

- Handicap card update.
  Handicap list to all faculty, report new cases, PRN.
- First-aid kits to classrooms, cafeteria, library, custodians.
- Prepare class lists.
- Schedule and conduct vision screening.
  Begin with upper grades.
  Chart results on health cards.
- Support team.
  Conference with school special education coordinator.
  Discuss nursing functions; emphasize team effort.
  Request meetings be held on day nurse is assigned to school.
  Remind one week minimum needed to complete health history and testing.
- Special education referrals, PRN.

Nursing Services Activity Table, Continued

October

- Vision screening.
  - Rechecks.
  - Refer, PRN.
  - Screen new students, PRN.
- Classroom teaching, consultation, PRN.
- Schedule and conduct audio-screening.
- Date to remember.
  - 40th day of school -- all special education referrals must be completed. Nursing impact: A large number of health histories and screenings may need to be completed prior to this date.

November

- Immunization Report due by November 15 to State Immunization Program Director.
- Audio-screening.
  - Rechecks.
  - Refer, PRN.
  - Screen new students, PRN.
  - Chart results on health records.
- Kindergarten assessments.
- School newsletter.
  - Submit articles concerning health matters, PRN.
- Restock supplies, housekeeping duties, PRN.
- Begin mid-school scoliosis screening.
  - Grade 6: Screen all students.
  - Grade 7: Recheck, screen, PRN.
  - Grade 8: Screen all students.

December

- Initiate vision screening -- should be completed by winter break.
- Health education programs.
  - Conference with appropriate teachers for planning.
- Referrals.
  - Encourage referrals during winter break.
  - Follow up on referrals and PRN.

Nursing Services Activity Table, Continued

January

- Dental health.
  - February is dental health month.
  - Plan program, speakers, films now.
- National School Nurse Day is the third Wednesday of January.
- Scoliosis.
  - Rechecks.
  - Referrals.
- Handicap cards.
  - Update condition with child or parent; record on back of card.

February

- Dental Health Month.
- Initial audio-screening should be completed by March 1.

March

- Growth and development program planning (menstruation/puberty educ.).
  - Plan films.
  - Invite parents to preview films.
- Scoliosis.
  - Rechecks.
  - Follow up on referrals.

April

- Handicap cards.
  - Check that all cards have been updated.
  - Destroy cards where condition no longer exists.
- Health cards.
  - Check all cards for screening results.
  - Screen all students who were inadvertently missed.

May

- Immunization process.
  - Send letters to students who become noncurrent during summer; date letter.
  - Send list of above to feeder school nurse if student is scheduled for promotion.
- Handicap cards.
  - Hand-carry handicap cards to feeder school for those students who are transferring.

CUMULATIVE HEALTH RECORDS

INSTRUCTIONS AND CODES FOR REPORTING

1. Names of Pupils

At the beginning of each school year, request teachers to fill out, by class, information indicated in the column. Also, the nurse should be notified during the school year of any pupil additions or dropouts in a class.

2. Vision Testing

For the initial test, test each eye separately, then both eyes together. When recording results, give the test date and mark P (pass) or F (fail) under the "Results" column, according to the criteria indicated below. When pupils fail the initial test, give a recheck test and record actual test results. If a pupil fails the recheck test, record the date that parents were notified. Use the "Reports and Notes" column for additional follow-up information.

a. Criteria for Initial Vision Test Failure

Symptoms of visual disturbance, or visual acuity in either eye or both eyes together of 20/40 or less, with or without symptoms.

b. Criteria for Referral

Symptoms of visual disturbance, or, after rechecking, visual acuity in either eye or both eyes together of 20/40 or less, with or without symptoms.

3. Hearing Testing

Indicate P (pass) or F (fail) when recording results of the sweep test, give a recheck sweep test. Record results. If pupils fail the recheck sweep test, give a threshold test. If pupil fails the threshold test, attach an audiogram to his/her health record. (Column space for dates of threshold tests is not provided; the date recorded for the recheck sweep test should be the same as the date of the threshold test, since they are customarily given together.) Indicate data that parents were notified of pupil's threshold test failure. The "Reports and Notes" column should be used for additional follow-up information.

Criteria for Sweep Test and/or Threshold Test Failure

Failure to hear two or more tones at the 25 decibel level (I.S.O. 1964 calibration) in one ear.

PUBLIC SCHOOL HEALTH RECORD, GRADES K-12

ew Mexico

( ) SPEC HEALTH PROBLEM

STUDEN o. ____________________

NAME (Last) ____________________ (First) ____________________ BIRTHDATE ____________________ LAST SCHOOL ATTENDED ____________________

ADDRESS (write in pencil) ____________________ PHONE (write in pencil) ____________________ FAMILY PHYSICIAN (write in pencil) ____________________

FATHER ____________________ MOTHER ____________________ FAMILY DENTIST (write in pencil) ____________________

HEALTH APPRAISAL RECORD

YEAR																
AGE & GRADE																
TEETH																
THROAT																
EYES																
EARS																
NOSE																
SKIN																
NUTRITION																
ORTHOPEDIC																
POSTURE																
HEARING	R															
	L															
VISION AT 20 FEET WITHOUT GLASSES	R															
	L															
	BOTH EYES															
VISION AT 20 FEET WITH GLASSES	R															
	L															
	BOTH EYES															
HEIGHT IN INCHES																
WEIGHT																

RECORD OF ILLNESS (STATE YEAR)

BONE OR JOINT TROUBLE ____________________
DIABETES ____________________
HEART TROUBLE ____________________
KIDNEY TROUBLE ____________________
RHEUMATIC FEVER ____________________
INJURIES OR OPERATIONS ____________________
SPECIAL HEALTH PROBLEM ____________________
____

STUDENT IS SUBJECT TO OR HAS HAD:

ASTHMA ________ OTHER ALLERGIES ________
EAR, NOSE OR THROAT TROUBLE ________
FAINTING SPELLS OR CONVULSIONS ________
FREQUENT COLDS OR BRONCHITIS ________
MUSCLE WEAKNESS OR PARALYSIS ________
SPEECH DISORDER ________
HEARING DIFFICULTY ________
BEHAVIOR DIFFICULTY ________

TUBERCULIN	DATE							
TESTS	RESULT							

IMMUNIZATION HISTORY

PRIMARY SERIES (Give Month & Year)

TYPE OF IMMUNIZATION	1	2	3	BOOSTERS		
DIPH., TETANUS, PERTUSSIS						
DIPHTHERIA TETANUS						
SABIN (ORAL) POLIOMYELITIS						
SALK POLIOMYELITIS						
RUBEOLA				MUMPS		
RUBELLA				SMALLPOX		

CODE: 0-SATISFACTORY 00-CORRECTION 1X-SLIGHT 2X-MOD 3X-MARKED DEFECT

Summary of Physician's Examination (Please check "No" or "Yes,"—If "Yes," specify recommendations below.) Dates:	NO	YES	NO	YES	NO	YES	NO	YES	NO	YES
1. Is there any defect of vision, hearing or speech for which the school could compensate by seating or other action:										
2. Is there any physical defect, including nutritional status, which would LIMIT the student's participation in classroom activities,										
in Gymnasium?										
in Competitive Athletics?										
in Swimming?										
3. Is student subject to conditions which make for classroom EMERGENCIES, e.g., Epilepsy, Fainting, Diabetes, Allergies? (Circle which)										
4. Is there any mental, emotional, or physical condition of a privileged nature for which the student should remain under your periodic observation?										
5. Does this student have any other medical problem with which the school should be concerned?										

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New Mexico
CUMULATIVE HEALTH RECORD
Grades 1-12

Name of Pupil ______________________ Sex ____ Birth Date ________
Addresses: ______________________
Schools: ______________________
____

Parents or ______________________ Addresses: ______________________
Guardians: ______________________ ______________________

IMMUNIZATION HISTORY

TYPE OF IMMUNIZATION	Dates Immunizations Received						
	Primary Series			Boosters			
	1st	2nd	3rd	1st	2nd	3rd	4th
DPT							
DT (pediatric)							
DT (adult)							
Polio (Salk)							
Polio (Sabin)							
Typhoid							
Other (specify)							

Smallpox date				
results				

COMMENTS, including description of any severe reactions:

HISTORY OF SIGNIFICANT HEALTH PROBLEMS
(indicate if detected)

Diabetes ______ Bone or Joint Trouble ______
Tuberculosis ______ Muscular Weakness or Paralysis ______
Heart Trouble ______ Allergies or Asthma ______
Speech Defect ______ Convulsions or Fainting Spells ______
Ear Defect ______ Emotional Problems ______
Eye Defect ______ Hernia (Rupture) ______
Weight Problems ______ Brain Injury or Disease ______
Other (specify) ______

Injuries or Operations ______

NOTES:

HEALTH SCREENING TEST RESULTS

			SCREENING TEST NOTES	TUBERCULIN TESTS*	
				Date	Results
V I S I O N*	SCREENING TEST	Date			
		Results			
	RECHECK TEST	Date			
		R			
		L			
		Both			
	Date Parents Notified				
H E A R I N G*	SWEEP TEST	Date			
		Initial			
		Date			
		Recheck			
	THRESHOLD TEST	Date			
		Results			
	Date Parents Notified				

*Vision Testing: Indicate P (pass) or F (fail) for Screening Test; record actual test results for recheck. If pupil wears glasses, test with glasses on and indicate in notes.
*Hearing Testing: Indicate P (pass) or F (fail). If "F", attach audiogram.

*Indicate "P" (positive) or "N" (negative). If "P", record number of millimeters and type of test.

PHYSICAL FITNESS TEST RESULTS

GRADE						
PULLUPS						
SITUPS						
SHUTTLE RUN						
STANDING BROAD JUMP						

GRADE							
50 YARD DASH							
SOFTBALL THROW (for distance)							
600 YARD RUN							

*Code: E Excellent G Good S Satisfactory P Poor

CUMULATIVE SCHOOL HEALTH RECORD

NAME ______ LAST FIRST MIDDLE

SCHOOL ______

ADDRESS ______ STREET CITY

FATHER ______

PHONE NO. ______

MOTHER ______

PUPIL'S BIRTHDATE ______

STEP-PARENT OR GUARDIAN ______

ILLNESS HISTORY — SEE BACK FOR MORE INFORMATION.

DIABETES	BONE OR JOINT PROBLEM	TUBERCULOSIS	RHEUMATIC FEVER
SEIZURE DISORDER	DENTAL PROBLEM	EAR PROBLEM	OPERATIONS
HEART PROBLEMS	SPEECH PROBLEM	EYE PROBLEM	INJURIES
FAINTING SPELLS	ASTHMA	ALLERGIES (Type)	OTHER (Specify)

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GRADE														
DATE (Month & Year)														
HEIGHT (Inches)														
WEIGHT (Pounds)														
GLASSES														
VISION (Right)														
VISION (Left)														
HEARING (Right)														
HEARING (Left)														
TYMPANOGRAM														
SCOLIOSIS														

IMMUNIZATIONS	PRIMARY SERIES			BOOSTERS		
	1st	2nd	3rd	1st	2nd	3rd
DPT — DT						
POLIO						
RUBELLA						
RUBEOLA						
MUMPS						

T B TEST				
RESULTS				
OTHER				

205

206

Rev. 8/81

WORKSHEET FOR SCHOOL HEALTH SERVICES

SCHOOL________________________GRADE____________

TEACHER_______________________YEAR_____________

NAME OF PUPILS	DPT Series	DPT Booster	DT Booster	Booster	Polio (Sabin)	Booster	Measles (Rubeola)	(German) Rubella Measles)	Smallpox	Other	VISION TESTING							HEARING SCREENING						Reports and Notes
											SCREENING			RECHECK TEST										
											Date	Results	Date	RE	LE	Both	Date Parents Notified	Date	Initial	Date	Recheck	Threshold	Date Parents Notified	
NAME: PARENT: ADDRESS: PHONE:																								
NAME: PARENT: ADDRESS: PHONE:																								
NAME: PARENT: ADDRESS: PHONE:																								
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NAME: PARENT: ADDRESS: PHONE:																								

WORKSHEET FOR SCHOOL HEALTH SERVICES
FOR SCHOOL NURSES, TEACHERS AND VOLUNTEERS

SCHOOL ____________________ GRADE ________

TEACHER ____________________ YEAR ________

NAMES OF PUPILS	IMMUNIZATIONS (MO. & YR.)					SKIN TESTS		VISION TESTING							HEARING TESTING						OTHER PROBLEMS					REPORTS AND NOTES
								INITIAL TEST		RECHECK TEST					SWEEP TEST											
	[illegible]	DPT	[illegible]	[illegible]	OTHER	DATE	RESULTS	DATE	RESULTS	DATE	RE	LE	BOTH	DATE PARENTS NOTIFIED	DATE	INITIAL	DATE	RECHECK	THRESHOLD	DATE PARENTS NOTIFIED	TYPE	DATE PARENTS NOTIFIED	[illegible]	IMPROVED	CORRECTED	
NAME PARENT ADDRESS PHONE																										
NAME PARENT ADDRESS PHONE																										
NAME PARENT ADDRESS PHONE																										
NAME PARENT ADDRESS PHONE																										
NAME PARENT ADDRESS PHONE																										
NAME PARENT ADDRESS PHONE																										
NAME PARENT ADDRESS PHONE																										
NAME PARENT ADDRESS PHONE																										

School Emergency Card

SCHOOL EMERGENCY MEDICAL & DENTAL CARE AUTHORIZATION ____________________ (NAME OF PUPIL)

If the above named pupil becomes seriously ill or injured at school and the family cannot be reached immediately for provision of instructions, I hereby authorize school personnel to call and or arrange for transportation of the pupil to our family physician.

Dr. ____________________

or dentist, Dr. ____________________

If this physician or dentist is not available, it is understood that the school will call a doctor and or will send the pupil, if necessary, to the nearest facility for emergency care.

(over)

It is understood, further, that I will pay for any emergency transportation and for any subsequent emergency care, unless the costs are otherwise covered by insurance.

(NOTE: Parents are responsible for notifying the school about any change of information contained on this card.)

Date __________ Signed ____________________ (PARENT OR GUARDIAN)

Telephone __________ (HOME) __________ (BUSINESS)

SCHOOL__________ GRADE__________ TEACHER__________ BIRTHDATE__________

/ MEDICAL REFERRAL CARD

Student's Name (Last) (First) (M.I.) Home Phone

Street Address Zip Code

Father's Name Place of Employment Bus. Phone Home Phone

Mother's Name Place of Employment Bus. Phone Home Phone

Please give the names of your family physician and family dentist to be called in case your son/daughter becomes ill or has an accident at school and you cannot be reached.

/

Family Physician Name Family Dentist Name

Please give the names of two relatives or friends who will assume the responsibility for your son/daughter in case of illness or accident until you can be reached. Please notify these persons of these arrangements. In case of any changes in the named persons, please notify this school in writing.

1.____________________ Name Address Home Phone

2.____________________ Name Address Home Phone

HEALTH PROBLEMS	
REGULAR MEDICATION	ALLERGIES

If, in the opinion of the principal/school nurse, service involving medical action or treatment is required and the parent cannot be contacted for consent, the parents hereby authorize school authorities to obtain medical service for or to transport for medical service the above student.

____________________ SIGNATURE OF PARENT OR GUARDIAN DATE__________

NOTE: PARENTS ARE RESPONSIBLE FOR NOTIFYING THE SCHOOL ABOUT ANY CHANGE OF INFORMATION CONTAINED ON THIS CARD.

LCPS FORM #14, Rev. 8/84 PLEASE RETURN IMMEDIATELY (OVER)

FOR OFFICE USE ____
Entered from ____
Records ordered ____
Health Problem
____
Immunizations
H - V - A - Screened
Glasses ____

Withdrawn ____ Do Not Release ____

____ ELEMENTARY SCHOOL

EMERGENCY INFORMATION

Please Print

Grade ____
Teacher ____
Date of Birth ____
Student Number ----------

STUDENT"S NAME ____
Last First Middle Initial
ADDRESS ____ Home Phone ____

My child has the following health problems (allergy, asthma, kidneys, wears glasses, etc.,____
____
My child has the following prescribed medication (s)____

FATHER'S NAME ____ EMPLOYER ____ PHONE ____

MOTHER'S NAME ____ EMPLOYER ____ PHONE ____

List two neighbors or nearby relatives whom you give authority to care for your child if you cannot be reached.

1. NAME ____
ADDRESS ____
PHONE ____

2. NAME ____
ADDRESS ____
PHONE ____

FOR NURSE'S USE ONLY

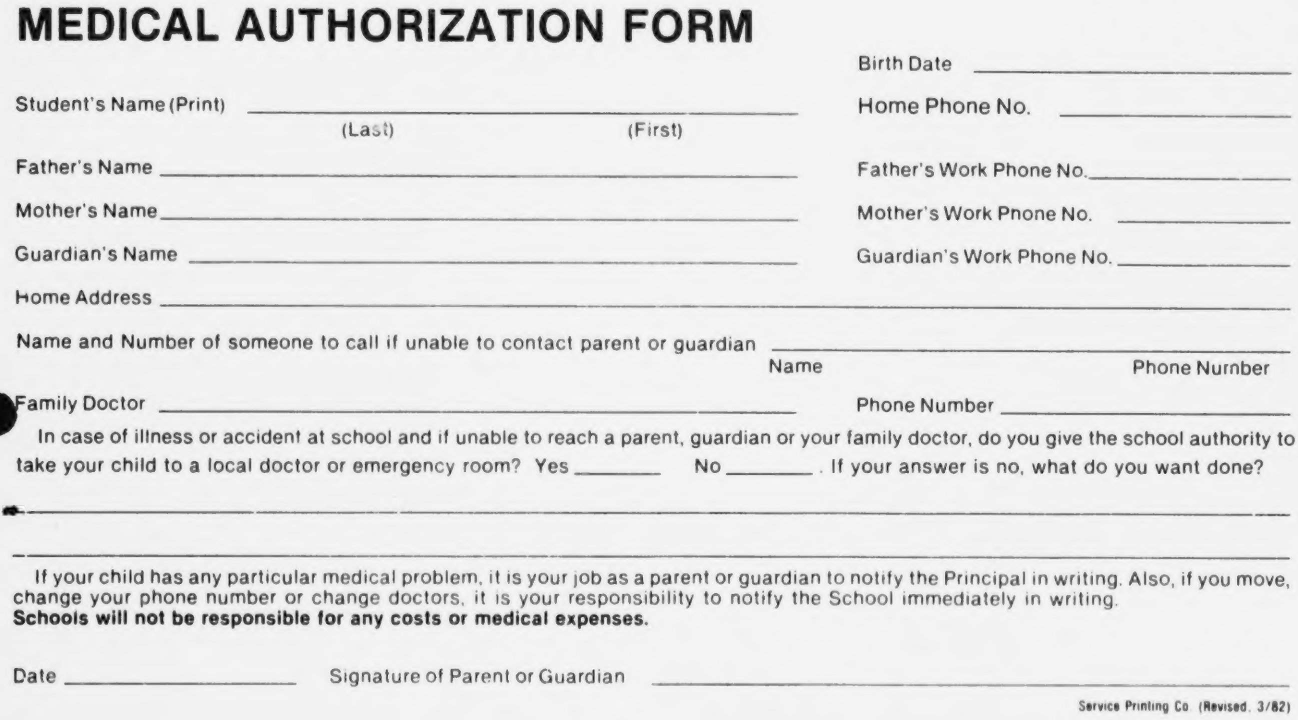
In case of illness or accident I request the school to contact me. If the school is unable to reach me I authorize the school to call the physician/dentist named below:

Local Physician's Name ____ Address ____ Phone ____
Local Dentist's Name ____ Address ____ Phone ____

If the physician/dentist is unavailable it is understood that the school will call a doctor/dentist and/or will send my child, if necessary, to UNM Medical Center for emergency care. It is also understood that I will pay for any emergency transportation and subsequent care, unless the costs are otherwise covered by insurance.

Parent's Signature ____

Medical Authorization Form



MEDICAL AUTHORIZATION FORM

Birth Date ____________

Student's Name (Print) ________________________ (Last) (First)

Home Phone No. ____________

Father's Name ________________________

Father's Work Phone No. ____________

Mother's Name ________________________

Mother's Work Phone No. ____________

Guardian's Name ________________________

Guardian's Work Phone No. ____________

Home Address ________________________

Name and Number of someone to call if unable to contact parent or guardian ________________ Name Phone Number

Family Doctor ________________________

Phone Number ____________

In case of illness or accident at school and if unable to reach a parent, guardian or your family doctor, do you give the school authority to take your child to a local doctor or emergency room? Yes ______ No ______ . If your answer is no, what do you want done?

____

____

If your child has any particular medical problem, it is your job as a parent or guardian to notify the Principal in writing. Also, if you move, change your phone number or change doctors, it is your responsibility to notify the School immediately in writing.
Schools will not be responsible for any costs or medical expenses.

Date ____________ Signature of Parent or Guardian ________________________

Service Printing Co. (Revised. 3/82)

PUPIL HEALTH HISTORY FORM

NOTE TO PARENTS: The school wishes to do all that it can to help you in protecting and promoting the health of your children. As an aid in doing this, it is necessary for the school to have accurate information about the health history of each pupil. Therefore, PLEASE FILL OUT THE FORM BELOW AND RETURN IT TO THE SCHOOL AS SOON AS POSSIBLE. All information obtained is confidential; it will be entered into the pupil's cumulative school health record, which will be made available only to school faculty. PLEASE KEEP THE SCHOOL INFORMED ABOUT ANY NEW HEALTH PROBLEMS OF YOUR CHILD THAT OCCUR DURING THE SCHOOL YEAR, I.E., PROBLEMS NOT DETECTED IN THE SCHOOL'S HEALTH PROGRAM.

Name of Pupil ____________________ Birth Date __________

Address ______________________________ Grade ______

Date of Last Medical Exam. for Pupil ______________ Date of Last Dental Exam. for Pupil ______________

Indicate the year that any of the following health problems were detected in this pupil:

Diabetes ________

Tuberculosis ________

Heart Trouble ________

Speech Defect ________

Ear Trouble ________

Eye Trouble ________

Weight Problem ________

Bone or Joint Trouble ____________

Muscular Weakness or Paralysis ________

Allergies or Asthma ____________

Convulsions or Fainting Spells ________

Emotional Problems ____________

Hernia (rupture) ____________

Brain Injury or Disease ____________

Other (specify and give date): ______________________

Operations or Series Injuries (specify and give date): __________

____

Parent's Signature ____________________ Date __________

SCHOOL HEALTH EXAMINATION FORM – MEDICAL

NOTE TO PARENTS: The school recommends a medical examination, including a tuberculin test, for all pupils entering this school for the first time, especially first grade children. Additional routine examinations should be received at least every five years thereafter (for example, in 6th grade and 11th grade). Take this form with you when your child is examined so that the doctor can fill it out. It is important that health problems be found in an early stage by your doctor. Also, the doctor's recommendations help the school to adapt its program to fit individual pupil health needs. WHEN THIS FORM HAS BEEN COMPLETED, RETURN IT TO THE SCHOOL AS SOON AS POSSIBLE. Results are considered confidential; they will be entered in the pupil's cumulative school health record, which will be made available only to school faculty. If you cannot arrange for an examination please notify the school nurse.

- -

NOTE TO PHYSICIAN: After examining the child named on the rereverse side of this form, please answer each question and include specific recommendations to the school as needed. The information requested is designed to help the school personnel to be aware of significant pupil health problems, especially those which may cause classroom emergencies or which may indicate need for limitation or adjustment of school activities. WHEN THE FORM HAS BEEN COMPLETED, PLEASE RETURN IT TO THE SCHOOL BY MAIL OR THROUGH THE CHILD'S PARENTS.

- -

Name of Pupil____________________ Birth Date __________ Grade _____

Address ____

SUMMARY OF PHYSICIAN'S EXAMINATION (please check "No" or "Yes" – – if "Yes", specify recommendations below)	No	Yes
1. Is there any physical or emotional problem for which special seating or other school action could help compensate?		
2. Is there any physical or emotional problem which would LIMIT the pupil's participation in any specific school activities?		
3. Does the pupil have a health problem which may create a CLASSROOM EMERGENCY, e.g., epilepsy, fainting spells, diabetes, heart trouble?		
4. Does the pupil have a physical or emotional health problem needing periodic supervision by a physician?		
5. Is there any other health problem, including nutritional status, with which the school should be concerned?		
6. Has the pupil completed all requirements of the school immunization law i.e., immunization against polio, diptheria, tetanus, and smallpox?		

PHYSICIAN'S RECOMMENDATIONS TO SCHOOL: ____________________

Physician's Signature________________________ Date ____________

Office Address ________________________ Telephone No. ____________

NURSING SERVICES

STUDENT HEALTH HISTORY

Name of Child____ Student #_______________

1. Pregnancy, birth, development

   a. Yes___ No___ Were there any difficulties during pregnancy?
   b. Yes___ No___ Did you take medication during pregnancy?
   c. Yes___ No___ Was this child carried to term?
   d. Yes___ No___ Were there any difficulties with labor and delivery?
   e. Yes___ No___ Were there difficulties after birth? (i.e., breathing, jaundice, etc.)
   f. Birthweight was_________lbs. _________oz.
   g. At what age did the child walk? __________
   H. At what age did the child talk? __________

   Additional information____
   ____
   ____

2. Has this child:

   a. Yes___ No___ Been hospitalized for serious illness, surgery, or accidents?
   b. Yes___ No___ Ever taken medication for longer than two weeks?
   c. Yes___ No___ Had any serious reactions to medicine or injections?
   d. Yes___ No___ Is your child taking any medication now?
   e. Yes___ No___ Had frequent colds or sinus infections?
   f. Yes___ No___ Had more than 3 ear infections in one year?
   g. Yes___ No___ Had a hearing problem?
   h. Yes___ No___ Had a vision problem?
   i. Yes___ No___ Are there any physical limitations?

   Explanation of any yes answers____
   ____
   ____

3. Has the student had any of the following?

   Yes___ No___ Allergies/hayfever
   Yes___ No___ Asthma
   Yes___ No___ Anemia
   Yes___ No___ High fever
   Yes___ No___ Convulsions
   Yes___ No___ Head injuries
   Yes___ No___ Migraine headaches
   Yes___ No___ Meningitis
   Yes___ No___ Heart disease
   Yes___ No___ Diabetes
   Yes___ No___ Kidney disease
   Yes___ No___ Measles
   Yes___ No___ Other

   Describe age and treatment, if any: ____
   ____
   ____

Is there a family history of these illnesses or other medical problems?__________________
____
____

4. What kind of difficulty is your child having right now, either at home or at school? (i.e., inattention, clumsiness, poor coordination) Describe.

5. Does your child feel a problem exists at school?

6. What does your child do well? What are his/her major strengths?

7. Family composition and social history.

8. Usual source of medical care ______________________________
Date of last physical exam. ________________

Findings: ____
____
____

Interviewing nurse ___________________________
Signature

NURSING SERVICES

HEALTH HISTORY SUMMARY

Name of Child____________________ School____________________ Date of Interview___________

Student #__________________ Birthdate____________________

Person Interviewed____________________ Relationship to Child____________________________

Can be contacted at____________________(phone number)

Report by____________________________
(School Nurse)

For significant data see:

1. Nursing Assessment: ( )
2. Natal Data: ( )
3. Developmental Data: ( )
4. Health History: ( )
5. Social History: ( )

Recommendations:

NURSING ASSESSMENT

______ % ____ Blood Pressure ______________
W ______ % ____ (optional)

VISION SCREENING: DATE ______________

A. Distance Vision (Snellen or equivalent)
without glasses: R 20/
L 20/

with glasses: R 20/
L 20/

B. Stereoacuity
Test used __________
passed ______
failed ______

C. Color Vision
Test used __________
normal __________
deficiency
noted ______

D. Motility (cross-cover test)
Exo-Movement noted Yes ___
No ___

E. Near Vision (indicated only if symptoms noted)
Test used ______________
passed _____
failed _____

Additional Information: ____

AUDIOMETRIC SCREENING: DATE ______________

Pure-tone Audiometry - screened at 25 dB;
l Frequencies ___ (OR)
passed - Both Ears /__/

	500	1,000	2,000	4,000	6,000	8,000 Hz
RIGHT EAR						
LEFT EAR						

Indicate dB level of threshold

OTOSCOPIC EXAM:
(Optional)

Additional information: ____

OBSERVATIONS:

Gross-motor/coordination: ____

Classroom (optional): ____

Summary of child's current status: ____

By ______________________
School Nurse

Date: ______________

FOR SIGNIFICANT INFORMATION SEE:
GENERAL
FAMILLY SOCIAL
BIRTH HISTORY DEVELOPMENT
HEALTH HISTORY

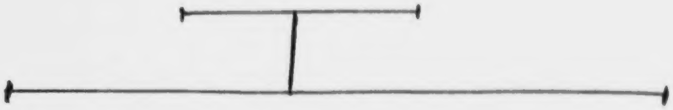
NAME DOB CA

INTERVIEWEE AND RELATIONSHIP TO CHILD

DATE REPORT BY

Circle, check items, expand comments.

GENETIC TREE



FAMILY SOCIAL

Family composition/relationships

Social adaptability and time spent
(what, where, how much)

SITTER

DAY CARE

T.V.

PREFERS...ALONE
OLDER
YOUNGER
SAME AGE

R CHILD'S MAJOR STRENGTH......DOES WELL
RESPONSIBILITIES

DISCIPLINE TYPE FREQUENCY
EFFECTIVENESS

PREGNANCY BIRTH DEVELOPMENT

Please tell me about....

PREGNANCY(X-RAYS, ILLNESS, SWELLING, BLEEDING, BLOOD PRESSURE)

MEDICATIONS DRUGS CIGERATTES ALCOHOL

FULL TERM WEEKS IF PREMATURE LABOR LENGTH INDUCED

DELIVERY (C-SECTION ANESTHETIC FORCEPS BREECH PLACENTAL

POST PARTUM MATERNAL PROBLEMS

BABY HAVE PROBLEMS
BREATHING JAUNDICE FETAL MONITOR
INCUBATOR OXYGEN FEEDING PROBLEMS
OTHER

TREATMENT

BIRTH WEIGHT LBS OZS. LENGTH OF HOSPITAL STAY

HEALTH OF BABY DURING FIRST YEAR FEEDING WEANED

CHILD DEVELOPMENT SIT CRAWL WALK TALK (WORDS) SENTENCES

TOILETING PROBLEMS

EPING SLEEPS WITH TO BED GETS UP NAPS

ANYONE LIVING WITH YOU HAVE SPECIAL PROBLEMS IE..HEALTH AGING
BEHAVIOR DRINKING DRUGS FINANCIAL

HEALTH HISTORY

Please tell me about your child's health now

MEDICAL CARE DATE OF LAST EXAM FINDINGS

DENAL CARE SOURCE DATE OF LAST EXAM FINDINGS

HOSPITALIZATIONS FOR SERIOUS ILLNESS, SURGERY, ACCIDENTS

TAKEN MEDICATIONS LONGER THAN 2 WEEKS WHY?

TAKING MEDICATIONS NOW? WHY?

FREQUENT COLDS/SINUS INFECTIONS MORE THAN 3 EAR INFECTIONS IN ONE YEAR?

HEARING PROBLEM???? EVER SEEN EAR/NOSE/THROAT DOCTOR?

VISION / EYE PROBLEM? EYE DOCTOR?

FAMILIAL HISTORY OF EYE PROBLEMS?

STUDENT HAD ANY OF THE FOLLOWING????? FAMILIAL HEALTH PROBLEMS?

ALLERGIES HAY FEVER
ASTHMA
ANEMIA RX
HIGH FEVER
CONVULSIONS
HEAD INJURIES
INGESTION OF POISONS/MEDS

MENINGITIS ENCEPHALITIS
HEART
DIABETES
KIDNEY DISEASE
CHILDHOOD DISEASES
CHILDHOOD DISEASES
CHRONIC MEDICAL OR OTHER

Please tell me ......

ANY PHYSICAL LIMITATIONS WHICH YOUR CHILD MAY HAVE NOW

WHEN NOTICED AND WHAT DONE ABOUT IT AND WHETHER SUCCESSFUL OR NOT

RECOMMENDATIONS

REFERRALS

DATE

SIGNATURE

SUGGESTED HEALTH EXAMINATION FORM

____

(Please print) NAME OF STUDENT CITY AND SCHOOL

Grade ______ Age ______ Height ______ Weight ______ Blood Pressure __________

Eyes Unequal pupils __________

Is there any condition for which this student requires an eye protector? ___Yes ___No

(Explanation) ______________________________

Is there any condition for which this student requires a mouth protector? ___Yes ___No

(Explanation) ______________________________

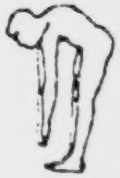
Cardiovascular __________ Murmur __________ Pulse __________

Liver __________ Spleen __________

Musculoskeletal

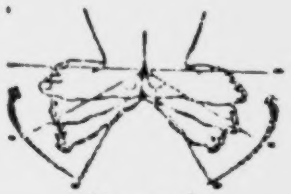
Flexibility: The lack of adequate flexibility or the appearance of excessive flexibility indicates that conditioning and training are necessary. It is not a disqualifying condition for participation.

Palms to floor:
- (a) < 10" from floor
- (b) > 10" from floor
- (c) Tips to floor
- (d) Fingers to floor
- (e) Palms to floor



Hips
- Less than 90°
- Greater than 90

If < 90° need screening program



Range of motion and strength for:

Shoulder	Normal	______	Abnormal	______
Elbow	Normal	______	Abnormal	______
Knee (Ligaments)	Normal	______	Abnormal	______
Ankle	Normal	______	Abnormal	______

Maturity Assessment for Football

The following screening is used primarily to assist in counseling students as to the appropriateness of their participation in football:

Tanner - Stage III - Genital development and pubic hair

Male:
- (a) Enlargement of penis which occurs initially in length. ___Yes ___No
- (b) Further growth of testes and scrotum ___Yes ___No
- (c) Hair darkens, becomes coarser and more curly; spreads sparsely over the junction of the penis. ___Yes ___No

I have reviewed the history and I certify that I have on this date examined this student and that on the basis of the examination requested by the school authorities and the student's medical history as furnished to me, it is permissable for this student to participate in all sports except those listed below:

____

____

Remarks: ____

____

____

Does this student need a physical examination prior to the next screening in two years? ________ Yes ________ No
If so, why? ____

____

Date of Examination ________________ Signed ________________________
Examining Physician

Physician's Address ________________________ Telephone: ______________

SUGGESTED SPORTS RELATED QUESTIONNAIRE: TO BE COMPLETED BY PARTICIPANT

Name ______________________ Birthdate ______________
Address ______________________ Telephone ______________
Parent/Guardian ______________________

Sports in which you want to participate ______________________

1. Have you ever been told not to participate in any sport? Yes No
Which sport and when? ______________________

2. Have you ever been unconscious or lost memory from any cause? Yes No
How many times? ______________.

3. Is there any history of fainting or loss consciousness during exercise? Yes No

4. Are you able to run one-half mile without stopping? Yes No

5. Do you or anyone in your family under 50 have a history of heart disease? Yes No

6. Do you have a seizure disorder (epilepsy)? Yes No

7. Have you ever broken or dislocated a bone? Yes No
Which one and when? ______________________

8. Have you ever had a knee or ankle injury? Yes No

9. Have you had any other injury that resulted in missing practice for more than 3 consecutive days or missing any competition? Yes No

10. Do you have any allergies? Yes No
Please specify (i.e. hayfever, hives asthma, drug reactions) ______________________

11. Do you have ear drum tubes or a perforated ear drum? Yes No

12. Do you wear any dental appliances (brace, false teeth)? Yes No
(Filled in by team M.D. - Is a mouth protector necessary?) Yes No

13. Do you wear glasses to play? Yes No.
Do you wear contact lenses? ________ Hard or soft? ________ Yes No

14. Have you had any illness lasting longer than one week? Yes No
What and when? ______________________

15. Are you under a physician's care for any reason now? Yes No
For what? ______________________

16. Do you take any medication on a regular basis? Yes No
Which ones? ______________________

17. Have you ever been in a hospital (except for tonsillectomy)? Yes No
For what? ______________________

[illegible]. Have you had any surgical operations? Yes No
Which ones? ______________________

UGGESTED SPORTS RELATED QUESTIONNAIRE

(Continued)
Page 2

9. Do you have only one kidney Yes No

0. Do you have vision in both eyes? Yes No

1. Do you have diabetes? Yes No

2. Do you have any worries about your health or questions you would like to discuss with us? Yes No

3. When did you receive your last immunization for Tetanus? ____________________ Was it a booster? Yes No

4. FOR WOMEN:

   (a) At what age did you experience your first menstrual period? ______________________________
   (b) In the last year what is the longest time you have gone between periods? ______________________________
   (c) Do you wish not to compete during menstruation? Yes No

hereby state that, to the best of my knowledge, my answers to the above uestions are correct.

______________________________________ ____________________
gnature (Participant) Date

hereby state that I have reviewed this medical history and find the answers the questions correct to the best of my knowledge. (Required for legal minors.)

______________________________________ ____________________
gnature (Parent) Date

hereby state that I have reviewed this medical history and find the answers to estions correct to the best of my knowledge.

______________________________________ ____________________
gnature (Physician) Date

INTERVAL HISTORY YEAR ______ TO ______

1. Sports to be participated in during this school year include:

Sport Level (Varsity, J.V., etc.)

a.
b.
c.

2. Have more than three consecutive days of practice or participation in a sport been missed because of injury? Yes ____ No ____
If yes, indicate:

a. Area Injured (R,L)__________,______________ b. Type of Injury______________
c. Date of Injury ______________ d. Days Restricted__________________________
e. Has the injured area returned to normal function? Yes____ No_____

3. Has more than one week of school been missed because of an illness? Yes____ No____
If yes, indicate:

a. Diagnosis ____________________________ b. Date____________________
c. Has the illness resolved with no significant permanent residue?
Yes_____ No_____

4. Have any significant medical problems occurred this past year? Yes_____ No_____
If yes, please indicate:

a. Diagnosis __________________________ b. Date______________________
c. Is the problem currently active? Yes______ No________

____
Signature (Student)

____
Address

____
Signature (Parent)

____
Address

PROPOSAL ON PERIODICITY FOR SPORTS PHYSICALS/HISTORIES IN NEW MEXICO SCHOOLS

Background: Currently, regulations require that a student's physical fitness to participate in competitive sports must be verified in writing by a licensed physician who has examined the student after May 1. The physical is effective through the school year.

New Proposal: The intent of the new proposal is to require physician physicals every 2 years and to help ensure that any changes in the student's physical condition of potential importance to sports fitness be noted between the time that physician physicals are performed.

Mechanics: A complete history and physical examination would be required at the time of initial entry into the sports program and every 2 years thereafter. This complete history and physical must be verified in writing by a licensed physician who has examined the student after May 1 and the physical shall be effective through the following two (2) school years.

In addition, an "interval history" would be required at the onset of a new sport and the onset of a new year. The interval history is a questionnaire completed by the parents and the student. If no new health problems are noted on the form, the interval history suffices for a student to enter the new sport or to begin the new school year. However, if a health problem is noted on the form, a physican history and examination will be required.

For example, if a boy enters school sports in the 7th grade, he needs a complete history and physical after May 1 of the year in which he enters 7th grade. This history/physical is kept on file in the school. If the boy wants to play football that Fall, this is all that is needed in terms of physical fitness certification. If the boy then decides to play baseball in the Spring, an interval history must be completed by the boy and his parents. If no new problems are noted, the interval history is kept on file and the boy is certified to play baseball. If a new problem had arisen, a physician statement (history and physical) would be required before he could play baseball.

Then, if he wants to play football in the 8th grade, he needs an interval history. Finally, if he wants to play baseball in 8th grade, a new interval history is required.

When he enters 9th grade, a new complete history and physical examination is required, as it was required for 7th grade.

Paperwork Issues: The complete history/physical forms would be kept in the school. If the physician indicates that the child is fit to participate in sports, the child can participate. The interval histories should be reviewed by school staff; if any problems are noted the physician must provide a complete history/physical and indicate that the child is fit to participate. If no problems are noted on the interval history then the form would simply be filed.

AUTHORIZATION TO ADMINISTER MEDICATION

The school system has adopted a policy that no employee, other than a licensed nurse, may administer medication to students. The system is not legally obligated to administer medicine to any student and nurses will do so only when necessary for a student to remain in school. This policy and its guidelines were developed in accordance with recommendations made by the American Academy of Pediatrics, the New Mexico State Department of Education and its School Nurse Advisory Committee, in coordination with the New Mexico Health Services Division and the New Mexico Pediatrics Society.

The purpose of this policy is to ensure that students do receive necessary medications according to their physician's orders and to ensure maximum safety for all concerned.

Should you be asked to complete one of these forms, please respond to all items. Feel free to contact the school nurse if you have any questions. Your cooperation is appreciated.

Dear Parents:

It has been brought to our attention that many parents have been sending medication to school with your children. Below is policy governing administration of medication at school and must be followed.

Introduction: As stated by the American Academy of Pediatrics' Committee on School Health; "Ideally, all medication should be given at home. If medications are to be given during school hours, the school board should provide a clearly defined policy in this area. It is recognized that at the present time many children are able to attend regular schools because of the effectiveness of medications in the treatment of chronic disabilities and illnesses".

Therefore, the following policy is proposed -

POLICY FOR ADMINISTRATION OF MEDICATIONS AT SCHOOL:

1. The physician must submit in writing his/her recommendations. This statement must include the following information; name of student, mane of drug, dosage of drug to be administered and precise schedule of administration, side-effects of the drug and periods of time during which administration of the drug is indicated.

2. The parents should provide written consent for administration of the drug by school personnel. In addition, the parents must provide a telephone number through which either parent may be reached in the event of an adverse reaction to the drug.

3. The child must be instructed by the parent or the physician on how to take his/her medication. Young children should be taught according to their level of capability. The child should know why he/she takes the medication and according to what schedule it should be given.

4. Older students may be allowed to assume responsibility for administration of their own medications, provided that self-administration is recommended, in writing, by the prescribing physician and the parent/guardian.

5. The container with the medication should be labeled with the name of the drug, the strength and correct dosage schedule for administration, the name of the student and the name of the physician.

6. The school nurse should be notified of all students taking medications at school.

7. Medications must be kept in a central locations within a locked closet or cabinet.

8. Non-prescription medications such as aspirin or cold tablets may not be administered without prior written consent of the parent.

All Levels

PROCEDURE GOVERNING ADMINISTRATION OF MEDICATIONS AT SCHOOL

Introduction: As stated by the American Academy of Pediatrics' Committee on School Health: "Ideally, all medication should be given at home. If medications are to be given during school hours, the school board should provide a clearly defined policy in this area. It is recognized that at the present time many children are able to attend regular schools because of the effectiveness of medications in the treatment of chronic disabilities and illnesses."
Pediatrics. 61:115-116, 1978

Therefore, the following procedures will be followed when it is absolutely necessary for a child to take medication during school hours.

Procedure for Administration of Medications at School

1. The physician must submit in writing his/her recommendations. This statement must include the following information: name of student, name of drug, dosage of drug to be administered and precise schedule of administration, side-effects of the drug and the period of time during which administration of the drug is indicated.

2. The parents should provide written consent for administration of the drug by the school nurse. In addition, the parents must provide a telephone number through which either parent may be reached in the event of an adverse reaction to the drug.

3. The child must be instructed by the parent or the physician on how to take his/her medication. Young children and handicapped or retarded children should be taught according to their level of capability. The child should know why he/she takes the medication and according to what schedule it should be given.

4. Students may be allowed to assume responsibility for administration of their own medications, provided that self-administration is recommended, in writing, by the prescribing physician and the parent/guardian.

5. The container with the medication should be labeled with the name of the drug, the strength and correct dosage schedule for administration, the name of the student and the name of the physician.

6. The school nurse should be notified of all students taking medications at school.

7. Medications must be kept in a central location within a locked closet or cabinet.

8. Non-prescription medications such as aspirin or cold tablets may not be administered without prior written consent of the parent.

Permission Form for Administering Medications in School

Student's Name ____ Birthday ___________

School ____ Grade ______________

Parent's/Guardian's Name ____

Address ____

Phone Number ____

- -

TO BE COMPLETED BY PHYSICIAN:

Medical condition which necessitates medication:

Name of medicine(s):

Directions for medication:

Options for administration (check one or more):

☐ Self-administration (unsupervised)
☐ Self-administration (supervised)
☐ Administration by nurse
or authorized personnel

________________________ Physician's Signature ________ Date

- -

TO BE COMPLETED BY PARENT/GUARDIAN:

The medication listed above must be taken during school hours as directed by the physician. I grant permission for the ______________________ Schools to exchange information with my child's doctor as deemed necessary.

I hereby request that the ______________________ Schools cooperate with the prescribing physician and assist with the administration of medication pursuant to the policy of the ______________________ Schools.

Recognizing that the ______________________ Schools are under no obligation to administer such medication, I hereby waive any claim for injury against the ____________________ Schools, or its employees, arising from the administration of such medication.

Furthermore, I agree to indemnify the ____________________ Schools and its agents and employees for any claims, suits, judgements, or costs of defense (including attorneys' fees) arising from any such claims.

______________________________ Parent's/Guardian's Signature ________ Date

______________________________ School Nurse's Signature ________ Date

______________________________ Principal's Signature ________ Date

PERMISSION TO GIVE MEDICATION

Name of Child______________________________

Name of Medication__________________________

Physician's Name___________________________

Reason for Medication________________________

Dosage______________________

Times to give_______________

Storage_____________________

How long to continue medication;

A. Today Only______

B. Until course of medication is completed______

C. As needed______

1. If as needed, under what circumstances would the medication be needed______________________________.

2. Time interval for administration______________.

What other information should the school staff know about this child and this medication? ________________________________

____.

I, the undersigned, give permission for the   Staff to give the above medication to my child, ______________________ (Name of Child), as directed by me. I release the   School of all liability provided the above instructions have been observed.

Parent/Guardian______________________________

Witness ______________________________

Date______________________________

PARENTAL AUTHORIZATION TO ADMINISTER MEDICATION

Student's Name ____

School ____

Date of Birth ____

* *

PARENT/GUARDIAN STATEMENT:

Please fill out (A) or (B) below and complete the form.

(A) I/We, the undersigned parent(s)/guardian(s) of ____________________ believe he/she is capable of carrying and administering his/her own medication at the appropriate time and in the appropriate way. I/We give my/our permission for him/her to do so.

OR

(B) I/We, the undersigned parent(s)/guardian(s) of ____________________ hereby request the school nurse to administer the above medication according to the physician's instructions. I/We agree to furnish the necessary prescribed medication in a properly labeled container, to provide replacement medication as necessary, and to notify the school nurse immediately if the physician or medication prescription is changed.

______________________________	______________	______________
Parent's/Guardian's Signature	Home Phone	Work Phone
______________________________	______________	______________
Parent's/Guardian's Signature	Home Phone	Work Phone

Date: ____________________________

PHYSICIAN'S AUTHORIZATION TO ADMINISTER MEDICATION

Student's Name ______________________________

School ______________________________

Date of Birth ______________________________

* *

PHYSICIAN'S STATEMENT

Name of drug ______________________________

Dosage ______________________________

Time of administration ______________________________

Duration of time student will be on this medication ______________

Special instructions regarding medication ______________

____

Contact me if the following signs or symptoms appear ______________

____

I believe this student is capable of carrying and administering his/her own medication at the appropriate time and in the appropriate way. ☐ Yes ☐ No

______________ ______________________________
Date Physician's Signature

Telephone ______________________________

SYMPTOMS NOTE TO PARENTS

TEACHER___________________ GRADE_____ CLASS PERIOD_____

____________ PUBLIC SCHOOLS

____________________________	______________________
Name of Child	Date

Dear Parent:

In observing the health of your child, the teacher and I have noted the following symptoms which we feel should be checked:

____

____

____

____

Please have the statement below completed --

Signed: ____________________________
Nurse

Principal: _______________________

Phone____________

School:_________________________

....

TO THE DOCTOR:

_____________________________was seen by me on___________

Glasses: (Required) ( ) Placed: Yes______
Not Required) ( ) No _____

Medical Treatment: Needed ( )
Not Needed ( )
May Return to School( )

Suggestions:

____
Signature of Doctor

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LETTER TO PARENTS

To: ______________________________ Date ______________
(Name of Parent)

From: ______________________ School ____________________
(Nurse)

Your child ____
(Nurse)

☐ Has failed a VISION TEST* given at school recently and should be examined by an eye doctor.

☐ Has failed a HEARING TEST* given at school recently and should be examined by a physician. Before this is done, I would like to discuss with you your child's hearing test results. Please call me for an appointment.

☐ Should be examined by your doctor because of the following symptoms which the teacher and I have noted ________________________________
____

*NOTE: These vision and hearing tests are screening tests and failure indicates only that the child should have a more complete examination by a doctor. If you have any questions about this, please contact me.

When your doctor completes the examination, please ask him/her to fill in the form below. You are then requested to see that the completed form is returned to the school nurse as soon as possible.

* *

REPORT OF EXAMINATION

1. Diagnosis: _______________________________________
____

2. If visual acuity examination was done:

Were glasses prescribed? ☐ Yes ☐ No
For constant wear? ☐ Yes ☐ No

3. Recommendations to school: ________________________
____
____

____________________ ______________________________
(Date) (Physician's Signature)

____________________ ______________________________
(Telephone) (Address)

NURSING SERVICES

General Referral to Physician for: Student ______________________________
School ______________________________ Birthdate ______________
Phone ____________________ Date ______________________
Contact person ______________________ Title ______________

School personnel who are working with the above student would appreciate your input in preparing an educational plan. You are invited to visit or call the school at any time. A parental release for medical information is attached.

Areas of concern noted at school: ______________________________

Teacher and School Nurse observations (classroom & playground)

____

Physician's Information:

1. Are there aspects of this student's health-related history, general physical findings or developmental progress that have a bearing on his/her educational needs? Please describe ______________________________

2. Are there specific neurological, sensory or other handicapping conditions at present? Please describe and if possible note how these may affect learning style and behavior.
____

3. Is the student receiving any medications and/or other therapies that might affect or relate to educational planning? Please describe ______________________________

   Note: A medication form is attached to be completed if it is necessary for medication to be administered at school.

4. Do you have any recommendations or suggestions for this student's educational plan? Please include any limitations or constraints about participation in various school activities. Please describe ______________________________

5. Are there any limitations or constraints about participation in various school activities? ______________________________

   Can this student participate in the regular P.E. programs? ___ yes ___ no
   ____ Yes, with restrictions described ______________________________

   OT/PT prescription: ______________________________

6. Other additional observations that you would like to share with the school:
____

Physician's signature ______________________
Date ______________

Vision Referral to Ophthalmologist or Optometrist

Student Name: ______________________ Grade: ____ Birthdate: __________
School: ___________________________ Date: __________

A referral is being made on the above named student for the problem of
____.

Vision assessment tools used and results: ______________________
____

Other symptoms noted at school: ______________________________
____

School Nurse ____________________
School Phone ____________________

- -

Reply from eye practitioner

Date of examination ____________________

General findings ______________________________________

Uncorrected acuity __________________ Corrected acuity __________

Prognosis ____

Recommendations ______________________________________

Is there a need to limit activity in any way? ☐ Yes ☐ No

If yes, please explain: ________________________________

Are there any other medical concerns for which the school needs to be aware? ☐ Yes ☐ No

If yes, please explain ______________________________________

Signature __________________________

Referral to Physician for Acute Illness

Student Name: ______________________ Birthdate: ______________

School: ______________________ Date: ____________

A referral is being made on the above-named student for the problem of ________
____
____

History: ____
Other observation: ____
____
____

School Nurse ________________
School Phone ________________

Note: A Medication Form is attached to be completed if it is necessary for medication to be administered at school.

- -

Physician's Reply

Name of physician: ______________________________

Date of examination: ____________________

Diagnosis: ________________________________

Treatment: ____

Limitations of activity? ____________________________________

Physician's signature ______________

TEACHER ______________

Reporting Nurse ______________ GRADE ____

NURSE HOME VISIT

Person served ______________ (last) ______________ (first)

Head of Household ______________ Address ______________

Date of Visit ______________ Of return visit ______________

Activity ______________

Referred by ______________

Visit recorded & reported ______________

Remarks: ______________

DETACH HOME VISIT REFERRAL HERE

****

NO ONE AT HOME NOTE

The Public School Nurse ______________

visited your home on ______________ at ______________

Since there was no answer, I will call ______________

would like you to call ______________ Phone ______________

School ______________ Will return ______________

Reason for visit ______________

If you would like to contact me, call the office no.
where a message may be left if I am not in.

Thank you for your co-operation

____
(Nurse's Signature)

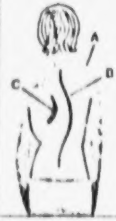
SPINAL SCREENING PROGRAM
Control Form

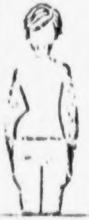
SCHOOL ____________________

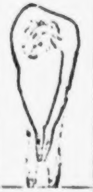
ADDRESS ____________________

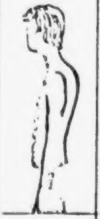
SCREENER ____________________

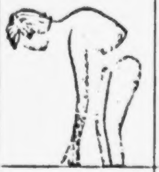
GRADE ________ CLASS SIZE ________ DATE OF SCREENING ________











STUDENT NAMES	SEX	DOB	A - Shoulder B - Spine C - Scapula	Hip	Chest Cage Hump	Round Back	Spine Hump	Under current medical treatment Y/N	Rescreen Y/N	Physician's Diagnosis & Treatment Report Y/N	No Follow-Up Necessary Y/N	Confir Refer t Physici Y/N

- D-50 -

VISION SELF-ASSESSMENT

Name: ______________________________ Date: ______________

Glasses: ☐ Yes ☐ No Period: 1 2 3 4 5 6 7 8

Date of last exam by an eye doctor: ______________________________

PLEASE READ CAREFULLY THE SIGNS AND SYMPTOMS OF VISION PROBLEMS LISTED BELOW: If the information is true for your vision, place a check in the box beside the condition described. Your responses will help you decide when you need a vision examination.

HAVE YOU NOTICED ANY OF THE FOLLOWING?

☐ 1. Blurry or double vision while looking at distant things (blackboards).
☐ 2. Blurry or double vision with close work (reading, crafts).
☐ 3. Need to squint in order to see more clearly.
☐ 4. Frequent headaches.
☐ 5. Eye itch, burn, or feel scratchy.
☐ 6. Eyes water easily.
☐ 7. Frequent eye infections (sties, red-rimmed, crusty or swollen eyelids).
☐ 8. Skip lines while reading or lose you place.
☐ 9. Read same lines over and over.
☐ 10. Get sleepy or bored after reading about 5-15 minutes.
☐ Other ______________________
____

HAVE OTHERS NOTICED ANY OF THE FOLLOWING ABOUT YOU?

☐ 11. Shuts or covers one eye; tilts head forward to read.
☐ 12. Blinking more than usual.
☐ 13. Squinting.
☐ 14. Sitting too close to T.V.
☐ 15. Eyes are crossed.
☐ 16. One eye wanders.
☐ 17. Rubs eyes a lot.
☐ 18. Reading problems.
☐ 19. Frustrated and irritable when doing close work.
☐ Other: ______________________
____

If you checked #1, 2, 3, 13, 15 or 16, an eye exam is advised NOW. Please check the box(es) below which best describe your vision assessment:

☐ 1. My vision is good. I don't need an exam now, but understand that it will be checked later in the school year.
☐ 2. I'm having some vision problems and would like to have my eyes checked.
☐ 3. I'm not having vision problems, but would like to have an eye exam for my own information

* *

TO BE FILLED IN BY THE SCHOOL NURSE:

RESULTS: OD _____ OS _____ OU _____
NEAR ______________
COLOR ______________
OTHER ______________

HEARING SELF-ASSESSMENT

PLEASE READ CAREFULLY THE SIGNS AND SYMTOMS OF HEARING PROBLEMS LISTED BELOW. If the information is true for you, circle the number beside the condition described. Your responses will help the school nurse in your hearing evaluation.

DO YOU HAVE

1. Frequent colds
2. Allergies
3. Frequent earaches
4. Problems with ear infections or drainage
5. An eardrum that burst
6. Trouble hearing your parents or teachers
7. Trouble paying attention

DO YOU

1. Listen to loud rock music
2. Use headphones to listen to music
3. Shoot guns
    a. Do you wear ear protection? ______________
    b. Have you always worn ear protection? ____________

HAVE OTHERS OBSERVED YOU HAVE

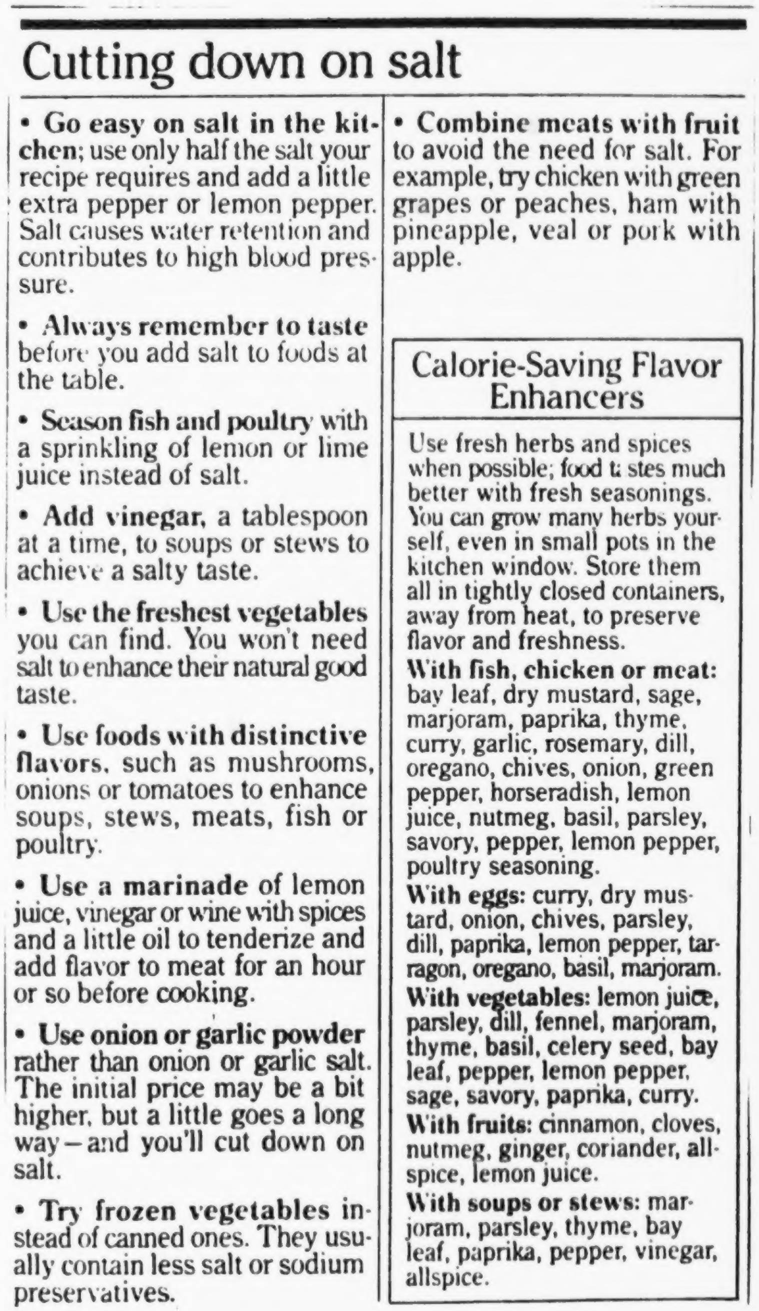
1. Trouble paying attention or answering when called
2. Tendency to listen to loud music

Is thereanything else the nurse should know about your ears, hearing?

Do you have any other health problems of which the nurse should be aware?

CUTTING DOWN ON SALT

Almost all of us consume more salt than we really need. The body can normally get along with less than a tenth of a teaspoon of salt a day. Most consume 2-3 teaspoons of salt a day. Healthy kidneys can easily get rid of excess salt in the urine. But some people are genetically destined to develop high blood pressure; for them excessive salt may become a contributing factor. The best general advice is to reduce the excessive intake of salt Linking excessive salt with the development of high blood pressure is circumstantial but most doctors and scientists believe cutting down is at least prudent and wise.
Children raised without acquiring the taste do just fine.



Cutting down on salt

- **Go easy on salt in the kitchen**; use only half the salt your recipe requires and add a little extra pepper or lemon pepper. Salt causes water retention and contributes to high blood pressure.
- **Always remember to taste** before you add salt to foods at the table.
- **Season fish and poultry** with a sprinkling of lemon or lime juice instead of salt.
- **Add vinegar**, a tablespoon at a time, to soups or stews to achieve a salty taste.
- **Use the freshest vegetables** you can find. You won't need salt to enhance their natural good taste.
- **Use foods with distinctive flavors**, such as mushrooms, onions or tomatoes to enhance soups, stews, meats, fish or poultry.
- **Use a marinade** of lemon juice, vinegar or wine with spices and a little oil to tenderize and add flavor to meat for an hour or so before cooking.
- **Use onion or garlic powder** rather than onion or garlic salt. The initial price may be a bit higher, but a little goes a long way – and you'll cut down on salt.
- **Try frozen vegetables** instead of canned ones. They usually contain less salt or sodium preservatives.
- **Combine meats with fruit** to avoid the need for salt. For example, try chicken with green grapes or peaches, ham with pineapple, veal or pork with apple.

Calorie-Saving Flavor Enhancers

Use fresh herbs and spices when possible; food tastes much better with fresh seasonings. You can grow many herbs yourself, even in small pots in the kitchen window. Store them all in tightly closed containers, away from heat, to preserve flavor and freshness.

With fish, chicken or meat: bay leaf, dry mustard, sage, marjoram, paprika, thyme, curry, garlic, rosemary, dill, oregano, chives, onion, green pepper, horseradish, lemon juice, nutmeg, basil, parsley, savory, pepper, lemon pepper, poultry seasoning.

With eggs: curry, dry mustard, onion, chives, parsley, dill, paprika, lemon pepper, tarragon, oregano, basil, marjoram.

With vegetables: lemon juice, parsley, dill, fennel, marjoram, thyme, basil, celery seed, bay leaf, pepper, lemon pepper, sage, savory, paprika, curry.

With fruits: cinnamon, cloves, nutmeg, ginger, coriander, allspice, lemon juice.

With soups or stews: marjoram, parsley, thyme, bay leaf, paprika, pepper, vinegar, allspice.

THE SNACK SHEET

Just about everybody snacks — and why not? Snacks give us a lift when we need it. Nutritious snacks even have a bonus — energy plus nutrients for action and healthier bodies.

What is a nutritious snack? Most people know that nutritious snacks contain very little sugar, fat or salt. But don't forget that nutritious snacks can **taste great** and don't have to cost much either.

A "rule of thumb": Choose snacks from the Four Food Groups—

Milk Meat
Vegetable-Fruit Bread-Cereal plus*

*If you choose bread or cereal snacks, combine them with food from one of the other three food groups.

What's your snacking mood?

There is a healthful snack for any occasion or mood.

Really Hungry!

hard cooked egg
nuts
seeds
burrito
taco
hamburger
pizza
leftovers
sandwich
cereal with milk
peanut butter and whole grain bread
granola
bran muffin
cheese

Thirsty!

cold milk
fruit juices:
- orange
- grapefruit
- tomato
- apple
- pineapple
- grape

water

Smooth!

yogurt
ice cream
custard
pudding
cottage cheese
papaya
banana
mango

Crunchy!

raw vegetables:
- carrots
- cabbage
- cauliflower
- broccoli
- bell pepper
- asparagus
- jicama
- zucchini

apple
corn on the cob
whole grain crackers & a nutritious spread

Juicy!

fresh fruit:
- orange
- tangerine
- grapefruit
- berries
- grapes
- peach
- plum
- pear
- pineapple
- kiwi
- cantaloupe
- watermelon
- tomatoes

NOTE: Children or adults who exercise little or are overweight should select raw vegetables and fresh fruits — limiting other snacks.

Why not tape this suggestion sheet to your refrigerator or cupboard door so it's handy next time you are looking for a snack for your children or yourself.

HEALTH ENVIRONMENT DEPARTMENT
STATE OF NEW MEXICO
Health Services Division
Nutrition Section

PAGINA DE MERIENDAS

Casi todo el mundo merienda, ¿y por qué no? Las meriendas nos dan energía cuando la necesitamos. Las meriendas alimentosas nos dan un beneficio adicional: además de la energía, nos dan los alimentos necesarios para que el cuerpo esté más saludable y pueda estar más activo.

¿Qué es una merienda alimentosa? Casi todos sabemos que las meriendas alimentosas contienen muy poca azucar, grasas o sal. Pero no se les olvide que las meriendas alimentosas son muy sabrosas y no tienen que costar mucho dinero.

Una buena idea: Escoga meriendas de los cuatro grupos de alimentos:

Leche	Carne
Verduras-Fruta	Pan-Cereal*

*Si usted escoge meriendas del grupo de pan y cereal auméntelas con comidas de uno de los otros grupos de alimentos.

¿Qué le gustaría merendar?
Hay una merienda alimentosa para cada gusto y ocasión.

¡Hambriento!

huevos cocidos
nueces
semillas
burrito
taco
hamburguesa
pizza
sobras de comida
emparedado
cereal con leche
mantequilla cacahuate o de maní, y pan de grano entero
granola
mollete de salvado
queso

¡Sediento!

leche fria
jugos de fruta de:
- naranja
- toronja
- tomate
- manzana
- piña
- uva

agua

¡Suave!

yogurt
helado
flan
pudín
requeson
papaya
plátano
mango

¡Crujiente!

verduras crudas:
- zanahorias
- col
- coliflor
- brecól
- pimiento verde
- espárrago
- jícama
- calabizitas

manzana
helote
galleta de grano entero untado con comidas nutritivas

¡Jugosa!

frutas frescas:
- naranja
- tangerina
- toronja
- uvas
- durazno
- ciruela
- peras
- piña
- kiwi
- melon
- sandía
- tomates

NOTA: Niños o adultos que hacen poco ejercicio o que tienen peso de más deben escojer verduras crudas y frutas frescas – limitando otras meriendas.

¿Por qué no pega este papel en la puerta de su refrigerador o gabinete para que esté a la mano la próxima vez que busque un alimento ligero para usted o sus niños?

HEALTH
ENVIRONMENT
STATE OF NEW MEXICO
Health Services Division
Nutrition Section

DIET RECALL

File Number: ☐☐.☐☐☐☐.☐☐

Last Name	First	Middle	Birth Date	Parent/Legal Guardian/Spouse

PLEASE FILL OUT THIS BOX ONLY
List everything you ate and drank yesterday, including amounts.

FOOD and DRINK	AMOUNT
EXAMPLE: *Cornflakes*	*1 Cup*
Milk	*1/2 Cup*

FOR OFFICE USE ONLY

FOOD GROUP				
MILK	MEAT-PROTEIN	VEGETABLE-FRUIT*	BREAD-CEREAL	ZERO FOODS

	MILK	MEAT-PROTEIN	VEGETABLE-FRUIT*	BREAD-CEREAL	ZERO FOODS
Total number of servings EATEN from each group:					
Total number of servings NEEDED from each group:					
DIFFERENCE (circle the deficiencies in serving numbers):					

**Enter A or C for good sources of these vitamins.*

HED/HSD 086 Revised 8/81

New Mexico Health and Environment Department - Nutrition Section

DIET HISTORY

File Number: ☐☐☐.☐☐☐☐☐.☐☐

Last Name	First	Middle	Birth Date	Parent/Legal Guardian/Spouse

1. Physician/Clinic

2. Diagnosis

3. Diet Prescription

4. Referral

5\.
a. Weight:
b. Height:

6. Medications

7. Vitamin/Mineral Supplements

8. Food Allergies

9. Food Dislikes

10. Activity Level
☐ light
☐ moderate
☐ heavy

11. Do you eat at regular times each day?
☐ yes ☐ no

12. How many times a week do you eat:
B? AM? L? PM? D? HS?

13. Who prepares food?

14. Special Considerations

15. FOOD PLAN

SERVING TOTALS	FOOD GROUP	TIME OF DAY					
		B	AM	L	PM	D	HS
	Milk						
	Meat/Protein						
	Vegetable						
	Fruit						
	Bread/Cereal						
	Fat						

16. Comments

ADOLESCENT NUTRITION RESOURCES for PROFESSIONALS

BOOKS AND BOOKLETS, including workshop proceedings, teaching manuals, and bibliographies (in order of date)

Counseling Adolescents for Dietary Change. T. J. Coates. Dallas: American Heart Association, 1982. 34 p.

Secondary Nutrition Education Materials and References. Oakland, CA: Society for Nutrition Education, 1981. 33 p.

Teenage Nutrition: Threat or Threshold to a Healthy Adult Life. Nutley, NJ: Vita Nutrition Information Service, Hoffman-LaRoche, Inc., 1980. 37 p.

Nutrition Update: Accent of Youth, Workshop proceedings. Washington, DC: America Economics Association, 1978. 89 p.

Teenage Nutrition and Physique. R. L. Huenemann, et al. Springfield, IL: Charles C. Thomas Publishers, 1974. 241 p.

"Health-Risk Eating Behaviors," Section VI in Promoting Adolescent Health: A Dial on Research and Practice. T. J. Coates, A. C. Petersen, and C. Perry, editors New York: Academic Press, 1982. 323-412 p.

JOURNAL ARTICLES, including symposia and chapters in books (in order of date)

"Nutrition - Crucial Factor in Adolescent Pregnancy," H. Jacobson. Food and Nutri News, 52(5):1-4, May-June 1981.

"Nutrition Concerns During Adolescence." Dairy Council Digest, 52(2):7-11, March- 1981.

"Nutrition in Adolescence - the Marabou Symposium." Nutrition Review, 39(2):37-115 February 1981.

"Nutrition Education for Grades 7-12: The Perspective of Pennsylvania Teachers and Administrators," T. Marr, B. Shannon, and G. B. Spanier. Journal of Nutrition Education, 12(3):148-152, July-September 1980.

"Nutrition and the Adolescent," B. Morgan. Nutrition and Health, 2 (5):1-6, 1980.

"Nutritional Concerns During Adolescence," D. Marino and J. King. Pediatric Clinic North America, 27(1):125-139, February 1980.

The Adolescent," F. P. Heald in Nutrition and Growth. D. B. Jelliffe and E. F. P. Jelliffe, editors. New York: Plenum Press, 1979. 239-252 p.

"The Adolescent Process and the Problem of Nutrition," S. Caghan. American Journal Nursing, 75(10):1728-1731, October 1975.

ADOLESCENT NUTRITION RESOURCES for PROFESSIONALS (continued)

"A Review of Teenage Nutrition in the United States," R. Huenemann. Health Services Report, 87(9):823-829, November 1972.

"Teen-age Food Habits," B. C. Schorr, D. Sanjur, and E. C.Erickson. Jopurnal of the American Dietetic Association, 61(4):415-420, October 1972.

"Nutritional Literacy of High School Students," J. Dwyer, J. Feldman, and J. Mayer. Journal of Nutrition Education, 2(3):59-66, Fall 1970.

PLACES TO CONTACT FOR FURTHER INFORMATION

Local Contacts (Listed in Telephone Directory)

	Ask for the:
City, county or state health department	Public Health Nutritionist
County or state extension service	Home Economist
Local dietetic association or Dial-A-Dietitian	In telephone directory
Local hospital	Registered Dietitian
Nutrition/dietetics department of state college or university	Nutrition Instructor
Local/district dairy council	

National Contacts

National Health Information Clearinghouse, P.O. Box 1133, Washington, DC 2001
(Telephone 800/366-4797. In Virginia, 703/522-2590).

ADOLESCENT NUTRITION RESOUCES for EDUCATORS

BOOKS AND BOOKLETS, including workshop proceedings, teaching manuals, and bibliographies (in order of date)

You - A guide to Food, Exercise and Nutrition. National Dairy Council. Rosemont, National Dairy Council, 1983. 32 p. (Note: There are two editions - one for with males and one for use with females).

Counseling Adolescents for Dietary Change. T. J. Coates. Dallas. TX: American He Association, 1982. 34 p.

Curriculum Guide: Nutrition Super Stars - grades 7 & 8. Phoenix: Arizona Depar Education, 1982. (Available from Home Economics Building, Room 322, Universit Arizona, Tucson, AZ 85721).

Curriculum Guide: The Florida Nutrition Education: A Basic Skills Approach. Tallahassee: Florida Department of Education, 1981. Language - Arts - A Word About Nutrition (grades 7-9); Math - Counting on Nutrition (grades 7-9); Scie The Nutrition Connection (grades 7-9); Social Studies - The Social Study of Nutrition (grades 7-9). (Available from Educational Products Distribution, F Department of Education, Tallahassee, FL 32301).

Curriculum Guide: Nutrition In a Changing World. University Park, PA: The Penns State University, 1981.
"A Curriculum for Junior High Health," James Rye, Karin Rosander, and Ida Lac 194 p.
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(Available from the Nutrition Foundation, 888 Seventeenth St., NW, Washington 20006).

Secondary Nutrition Education Materials and References. Oakland, CA: Society for Nutrition Education, 1981. 33 p.

Curriculum Guide: Food...Your Choice. Rosemont, IL: National Dairy Council, 1980.
"Level 4: Health 7-10"; activity cards; support materials.
"Level 4: Home Economics 7-10"; activity cards; support materials.

Nutrition and the School Age Child. Allene Vaden, editor. Denver, CO: School Foo Service Research Review, Fall 1979. 134 p.

For Teenagers Only: Change Your Habits to Change Your Shape. J. Ikeda. Palo Alt Bull Publishing Company, 1978. 126 p.

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Nutrition Source Book. Rosemont, IL: National Dairy Council, 1978. 40 p.

JOURNAL ARTICLES, including chapters in books (in order of date)

"Health-Risk Eating Behaviors," Section VI in Promoting Adolescent Health: A Dial Research and Practice. T. J. Coates, A. C. Petersen, and C. Perry, editors. New York: Academic Press, 1982. 323-412 p.

ADOLESCENT NUTRITION RESOURCES for EDUCATORS (continued)

"Nutrition - Crucial Factor in Adolescent Pregnancy," H. Jacobson. Food and Nutr[illegible]on News, 52(5):1-4, May-June 1981.

"Nutrition Concerns During Adolescence." Dairy Council Digest, 52(2):7-11, March-April 1981.

"Adolescence: Feeding the Fast-Food-Freaks" in Jane Brody's Nutrition Book. Jane Brody. New York: W. W. Norton and Company, 1981. 389-403 p.

"Chapter 8: Pubescence and Adolescence" in Nutrition in the Life Span. Virginia Beal. New York: John Wiley and Sons, 1980. 323-346 p.

"The Food Eaters Almanac." Current Health 2, 6(1):3-13, September 1979.

AUDIOVISUALS

Nutrition for Teenagers Only, (3 filmstrips). Sunburst Communications, Inc., Pleasantville, NY. Avg. 78 frames, 13 min., color; audiocassette; teachers guide. 1982.

Food Becomes You: Nutrition and the Human Body, (3 filmstrips). Tupperware Educationa Services, Orlando, FL. Avg. 80 frames, 11 min., color; audiocassettes; teachers guides. 1979.

Nutrition Is..., (film). The Sugar Association, Washington, DC. 16mm, 18 min., color 1976.

Eating on the Run, (film) Alfred Higgins Productions, Los Angeles, Ca. 16 mm, 1[illegible]in. color. 1975.

PLACES TO CONTACT FOR FURTHER INFORMATION

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Local hospital	Registered Dietitian
Nutrition/dietetics department of state college or university	Nutrition Instructor
ate department of education	Child Nutrition Specialist
Local/district dairy council	

National Contacts

National Health Information Clearinghouse, P.O. Box 1133, Washington, DC 20013. (Telephone 800/366-4797. In Virginia, 703/522-2590).

Food and Nutrition Information Center, National Agricultural Library Building, Room 30 Beltsville, MD 20705. (Telephone 301/344-3719).

ADOLESCENT NUTRITION RESOURCES for CONSUMERS

BOOKS AND BOOKLETS (in order of date)

The Hassle-Free Guide to a Better Diet, Leaflet #567. U.S. Department of Agriculture, Washington, DC; Office of Governmental and Public Affairs, U.S. Department of Agriculture, 1980. 2 p. (Available from Superintendent of Documents, U.S. Government Printing Office, Washington, DC 20402).

Discovering Nutrition. H. Kotaluk. Perioa, IL: Charles A. Bennett Publishing Company, 1980. 224 p.

For Teenagers Only: Change Your Habits to Change Your Shape. J. Ikeda. Palo Alto, CA Bull Publishing Co., 1978. 126 p.

A Girl and Her Figure. R. Leverton. Rosemont, IL: National Dairy Council, 1976. 24 p (Available from National Dairy Council, 6300 N. River Road, Rosemont IL 60018, or local Dairy Council chapter).

A Boy and His Physique. W. H. Gregg. Rosemont, IL: National Dairy Council, 1976. 36 p. (Available from National Dairy Council, 6300 N. River Road, Rosemont, IL 60018, or local Dairy Council chapter).

"Adolescence: Feeding the Fast-Food Freaks" in Jane Brody's Nutrition Book. Jane Brody. New York: W. W. Norton and Company, 1981. 389-403 p.

MAGAZINE ARTICLES, including chapters from books (in order of date)

"The Food Eaters Almanac," Current Health 2, 6(1):3-13, September 1979.

"The Truth About Teenage Food Fads," A. M. Marks. Parents' Magazine, 52(3): 44-45, 70, March 1977.

"Make Snacking Healthful," Jean Mayer. Family Health, 6(3):32-33, March 1974.

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Nutrition/dietetics department of state college or university	Nutrition Instructor
Local/district dairy council	

National Contacts

National Health Information Clearinghouse, P.O. Box 1133, Washington, DC 20013. (Telephone 800/366-4797. In Virginia, 703/522-2590).

Anorexia Nervosa and Bulimia Support Organizations

Bulimia Anorexia Self-Help (BASH)
Ballas-Parkway Medical Center
522 North New Ballas Road, Suite 206
St. Louis, Missouri 63141
Phone: (314) 567-4080

American Anorexia Nervosa Association, Inc.
133 Cedar Lane
Teaneck, New Jersey 07666
Phone: (201) 836-1800

National Association of Anorexia
Nervosa & Associated Disorders (ANAD)
P. O. Box 271
Highland Park, Illinois 60035
Phone: (312) 831-3438

STUDENTS AGAINST DRIVING DRUNK (SADD)

The purpose of the SADD chapters is to organize students to combat the number one killer of their age group--deaths due to drinking and driving. SADD educates students concerning the problem of drinking and driving and helps each student become aware of the alcohol problem as it exists on the local, state and national levels.

SADD has four goals:

1. To help eliminate the drunk driver and save lives.
2. To alert high school students to the dangers of drinking and driving.
3. To conduct community alcohol awareness programs.
4. To organize peer counseling programs to help students who may have concerns about alcohol.

To implement the SADD goals, a three step approach including school, community and home has been developed:

1. Implementation of the SADD curriculum within the high schools and establishment of a SADD chapter.
2. Student-parent contract
3. Community awareness program

SADD is a proven lifesaving program because it is student motivated. The program promotes positive peer pressure. Students believe in the concept of not drinking and driving and share that message with fellow teens. Schools can join this student campaign to save lives by organizing a SADD chapter in their school.

SADD is the first program of its kind to involve the school, community and the home in public awareness and community spirit to combat the drinking-driving issue. The slogan of SADD is: "If We Can Dream It...It Can Be Done."

NO ONE TAKES BETTER CARE OF YOU THAN YOU!

Blood pressure, measured in millimeters of mercury, is the force created by the pumping action of the heart muscle and the resistance and expansion of the walls of your arteries.

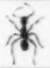
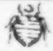
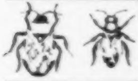
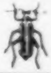
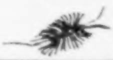
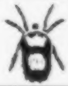
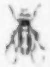
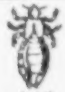
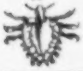
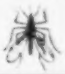
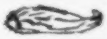
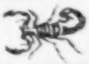
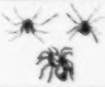
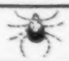
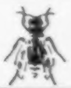
Blood pressure is dynamic. Blood pressure in a person varies from moment to moment throughout the day. If you are excited or frightened, or when you exercise, your heart beats faster and harder than usual and increases your blood pressure to meet the increased physical needs for oxygen and energy. Blood pressure also changes with relaxing, sleeping, drinking coffe, tea, or cola and taking drugs. It is also affected by weight and smoking habits.

The first number (called SYSTOLIC) represents the highest pressure in your system, while the heart is working. The second number (called DIASTOLIC) is the pressure in your system as it relaxes and waits for another surge of blood.

Blood pressure can be elevated by disease or stress, and can be depressed by severe bleeding, shock, malnutrition, and some kinds of alcohol and drug abuse. "Low" blood pressure is usually not a problem unless accompanied by dizziness and frequent fainting.

Blood pressure which is 140/90 for more than one reading should be evaluated by your doctor.

There are thousands of insects which are capable of causing discomfort through their bites and stings. The following list consists of some of the insects in the U.S. that are commonly known and easily identifiable. The symptoms indicated are normal reactions; however, if a person is allergic to a specific insect bite, the reaction is much more severe and A PHYSICIAN SHOULD BE CONTACTED IMMEDIATELY.

	INSECT	AREA OF BITE	SYMPTOMS
	Ant Fire Ant Velvet Ant	Any exposed skin	Local pain, redness, possible swelling and infection.
	Bedbug	Any exposed skin	Small, hard swelling. White in color, possible inflammation.
	Bee Bumblebee Honeybee	Usually head and arms; any exposed skin	Local inflammation, pain, swelling.
	Blister Beetle	Any exposed skin	Body tissues and fluids produce blisters on human skin.
	Centipede	Any exposed skin, particularly lower limbs	Local pain, swelling and possible infection.
	Chigger	Any area, primarily lower limbs	Itching, rash, possible fever and infection.
	Flea	Any area	Redness, itching, possible swelling.
	Fly Deerfly Horsefly Midge Fly Sandfly Stable Fly	Any exposed skin	Local pain, redness, possible swelling and infection.
	Louse Body Louse	Neck, back abdomen; dwell in seams of clothing	Blood specks on skin; severe itching; rough, red skin.
	Crab Louse	Genital region, eyebrows, hair of armpits	Blue or gray stains under skin, severe itching.
	Head Louse	Hair of head	Itching and irritation of scalp.
	Mite	Any area	Redness, itching, possible swelling.
	Mosquito	Any area	Itching, redness, local swelling and possible infection.
	Puss Caterpillar	Any exposed skin	Burning, itching, red welts, swelling, possible nausea.
	Scorpion	Usually foot and ankle area	Severe pain, swelling, fever. Some species may be fatal.
	Spider Black Widow Brown Recluse Tarantula	Any exposed skin, usually bites only if threatened	Local redness, pain and swelling, possible nausea and paralysis. Difficult breathing with Black Widow Spider bites.
	Tick	Any exposed skin	Local redness, itching; possible infection. Some species induce fever and paralysis.
	Wasp (Hornet, Yellow Jacket)	Exposed skin; usually head and arms	Local redness, pain, swelling; possible infection.

weight height [illegible]

BOYS PERCENTILE				GIRLS PERC	
10th	50th	90th	Age	10th	50th
6.1 lb.-18.7 In.	7.2 lb.-19.9 In.	8.4 lb.-21.1 In.	Birth	5.7 lb.-18.3 In.	7.1 lb.-19.
10.5 lb.-22.7 In.	13.2 lb.-24.1 In.	15.7 lb.-25.4 In.	3 mon.	9.9 lb.-22.1 In.	11.9 lb.-23
14.6 lb.-25.4 In.	17.3 lb.-26.7 In.	20.1 lb.-28.1 In.	6 mon.	13.5 lb.-24.6 In.	15.9 lb.-25
17.5 lb.-27.2 In.	20.2 lb.-28.5 In.	23.1 lb.-29.9 In.	9 mon.	16.2 lb.-26.4 In.	18.9 lb.-27
19.5 lb.-28.7 In.	22.4 lb.-30.0 In.	25.4 lb.-31.4 In.	12 mon.	18.1 lb.-27.9 In.	21.0 lb.-29
21.9 lb.-31.0 In.	25.3 lb.-32.4 In.	28.8 lb.-34.1 In.	18 mon.	20.5 lb.-30.4 In.	23.9 lb.-31
23.9 lb.-32.9 In.	27.8 lb.-34.5 In.	31.5 lb.-36.3 In.	24 mon.	22.6 lb.-32.5 In.	26.2 lb.-34
28.0 lb.-36.4 In.	32.4 lb.-38.0 In.	36.7 lb.-40.0 In.	36 mon.	26.6 lb.-35.9 In.	30.7 lb.-37
31.4 lb.-38.3 In.	36.8 lb.-40.5 In.	42.6 lb.-42.6 In.	4 years	30.5 lb.-38.0 In.	35.2 lb.-40
35.2 lb.-40.8 In.	41.2 lb.-43.3 In.	47.8 lb.-45.4 In.	5 years	33.6 lb.-40.4 In.	38.9 lb.-42
39.0 lb.-43.1 In.	45.6 lb.-45.7 In.	53.6 lb.-48.0 In.	6 years	36.9 lb.-42.7 In.	43.0 lb.-45
43.1 lb.-45.3 In.	50.4 lb.-47.9 In.	60.3 lb.-50.4 In.	7 years	40.5 lb.-44.7 In.	48.2 lb.-47
47.2 lb.-47.3 In.	55.8 lb.-50.0 In.	68.5 lb.-52.6 In.	8 years	45.1 lb.-46.7 In.	54.8 lb.-49
51.4 lb.-49.3 In.	62.0 lb.-52.0 In.	78.4 lb.-54.9 In.	9 years	50.5 lb.-48.8 In.	62.8 lb.-52
56.3 lb.-51.2 In.	69.3 lb.-54.1 In.	90.0 lb.-57.3 In.	10 years	56.8 lb.-51.0 In.	71.8 lb.-54
62.1 lb.-53.2 In.	77.8 lb.-56.4 In.	102.7 lb.-59.9 In.	11 years	63.9 lb.-53.4 In.	81.5 lb.-57
69.4 lb.-55.2 In.	87.7 lb.-58.9 In.	116.3 lb.-62.8 In.	12 years	71.7 lb.-56.0 In.	91.6 lb.-59
78.5 lb.-57.4 In.	99.1 lb.-61.6 In.	130.4 lb.-65.7 In.	13 years	80.2 lb.-58.3 In.	101.7 lb.-61

The figures used in this chart were converted from Hamill, P.V.V. et al. Physical Growth: National Center for Health Statistics Percentiles. The American Journal of Clinical Nutrition 32:607-629, 1979.

HEIGHT AND WEIGHT CHART - ADULTS

OBESITY AND YOUR HEALTH

TREATMENT ADVISED. If you are 20 percent above desirable weight, you have an "established health hazard" and should seek medical treatment, according to an expert panel's report to the National Institutes of Health. Health problems linked to obesity include diabetes, high blood pressure, several types of cancer, arthritis and diseases of the heart and gall bladder. The panel relied upon the following table of desirable weights, issued in 1983 by the Metropolitan Life Insurance Company and based on levels at which death rates are lowest among people between ages 25 and 59. The weights include 5 pounds of clothing for men, 3 pounds for women. Heights include shoes with 1-inch heels.

MEN

Height Feet	Height Inches	Small Frame	Medium Frame	Large Frame
5	2	128-134	131-141	138-150
5	3	130-136	133-143	140-153
5	4	132-138	135-145	142-156
5	5	134-140	137-148	144-160
5	6	136-142	139-151	146-164
5	7	138-145	142-154	149-168
5	8	140-148	145-157	152-172
5	9	142-151	148-160	155-176
5	10	144-154	151-163	158-180
5	11	146-157	154-166	161-184
6	0	149-160	157-170	164-188
6	1	152-164	160-174	168-192
6	2	155-168	164-178	172-197
6	3	158-172	167-182	176-202
6	4	162-176	171-187	181-207

WOMEN

Height Feet	Height Inches	Small Frame	Medium Frame	Large Frame
4	10	102-111	109-121	118-131
4	11	103-113	111-123	120-134
5	0	104-115	113-126	122-137
5	1	106-118	115-129	125-140
5	2	108-121	118-132	128-143
5	3	111-124	121-135	131-147
5	4	114-127	124-138	134-151
5	5	117-130	127-141	137-155
5	6	120-133	130-144	140-159
5	7	123-136	133-147	143-163
5	8	126-139	136-150	146-167
5	9	129-142	139-153	149-170
5	10	132-145	142-156	152-173
5	11	135-148	145-159	155-176
6	0	138-151	148-162	158-179

CENTIGRADE / FAHRENHEIT EQUIVALENTS

CENTIGRADE	– FAHRENHEIT EQUIVALENTS
36.0	96.8
36.5	97.7
37.0	98.6
37.5	99.5
38.0	100.4
38.5	101.3
39.0	102.2
39.5	103.1
40.0	104.0
40.5	104.9
41.0	105.8
41.5	106.7
42.0	107.6

Formula: To convert degrees C -to degrees F
Multiply by 9/5, then add 32.

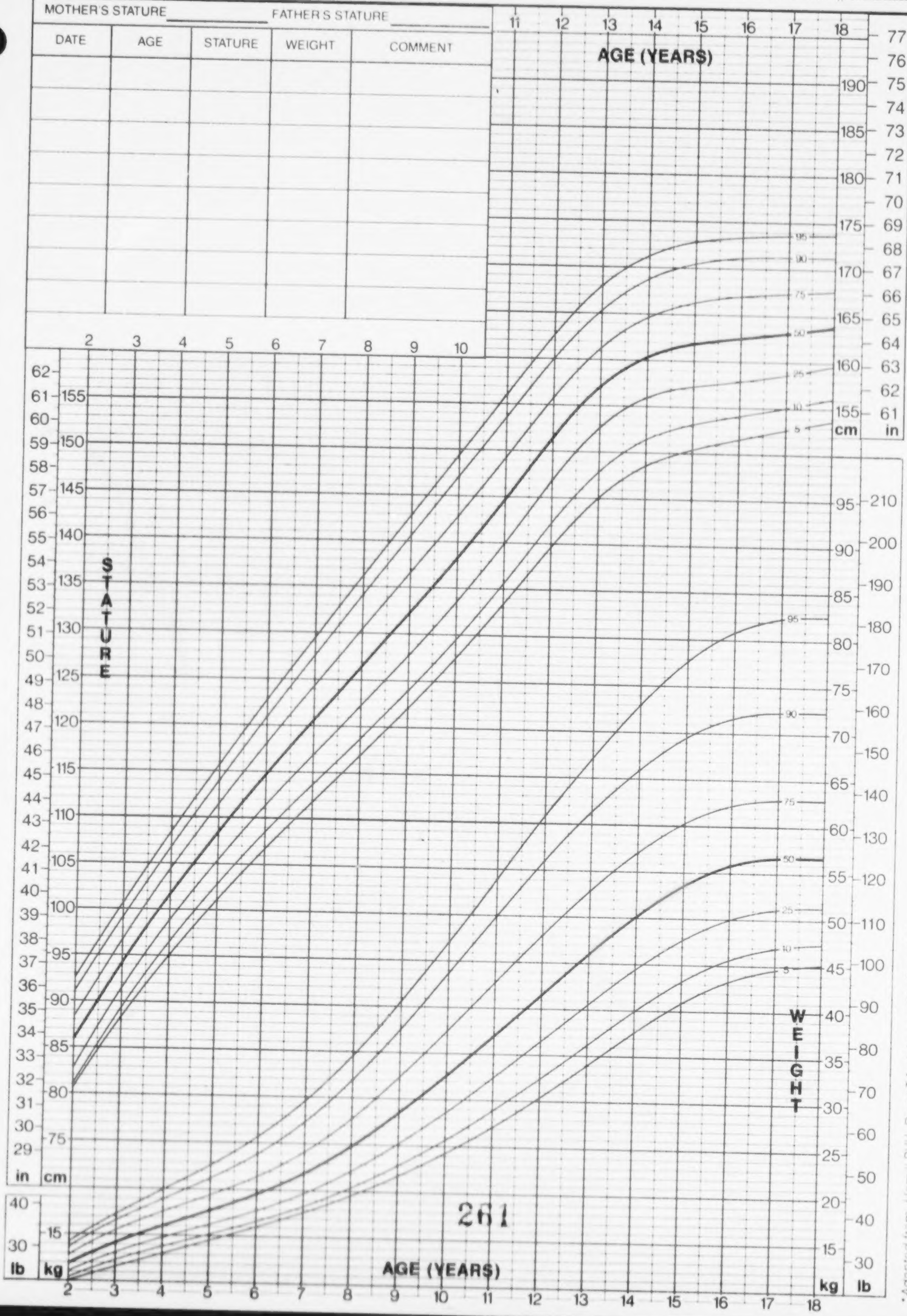
GIRLS: 2 TO 18 YEARS
PHYSICAL GROWTH
NCHS PERCENTILES*

NAME ____________________ RECORD # ____________________

MOTHER'S STATURE __________ FATHER'S STATURE __________

DATE	AGE	STATURE	WEIGHT	COMMENT

Ross Growth & Development Program™



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*Adapted from: Hamill PVV, Drizd TA, Johnson CL, Reed RB, Roche AF, Moore WM: Physical growth: National Center for Health Statistics percentiles. AM J CLIN NUTR 32:607-629, 1979. Data from the National Center for Health Statistics (NCHS), Hyattsville, Maryland

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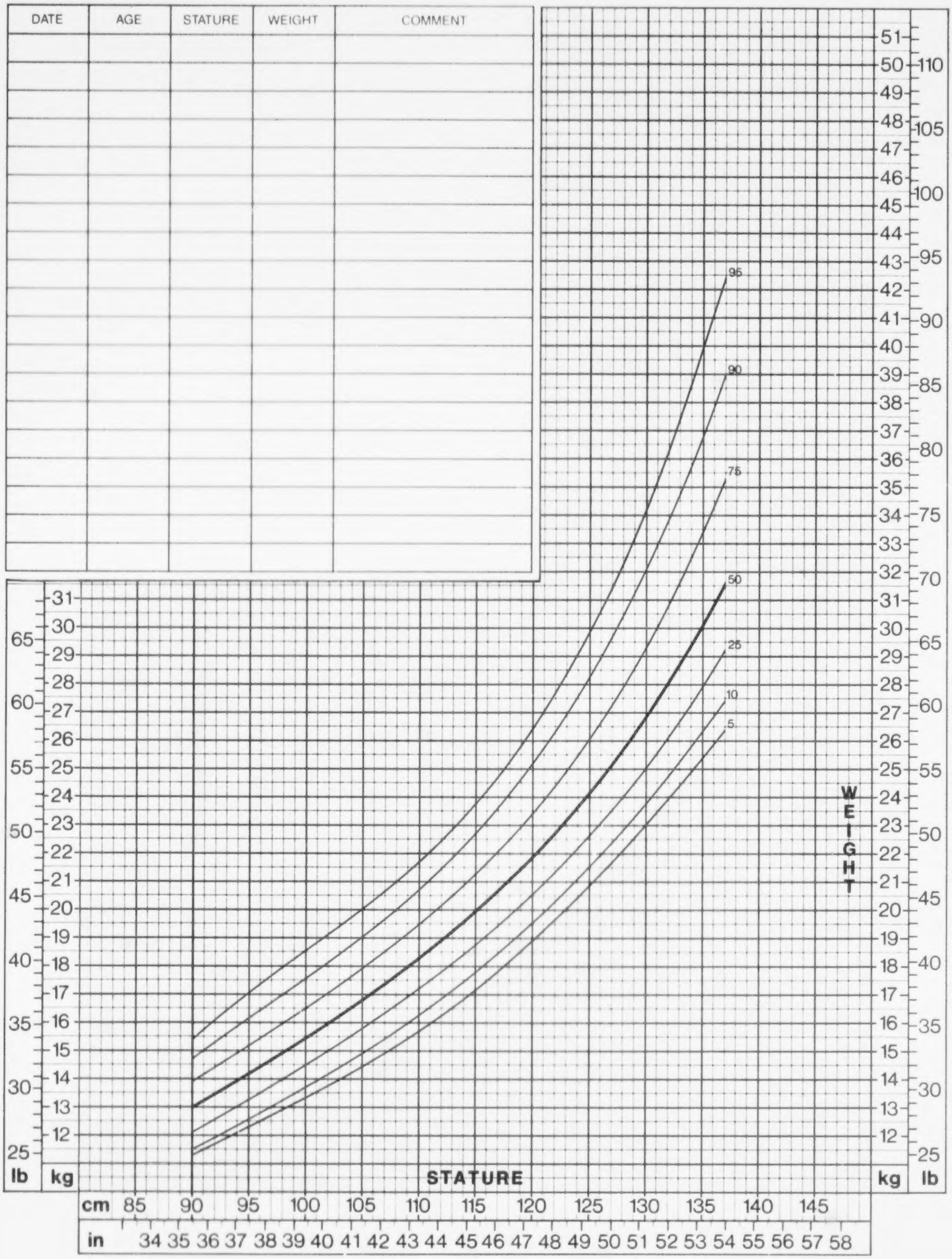
GIRLS: PREPUBESCENT
PHYSICAL GROWTH
NCHS PERCENTILES*

NAME ______________________ RECORD # __________

DATE	AGE	STATURE	WEIGHT	COMMENT



*Adapted from: Hamill PVV, Drizd TA, Johnson CL, Reed RB, Roche AF, Moore WM: Physical growth: National Center for Health Statistics percentiles. AM J CLIN NUTR 32:607-629, 1979. Data from the National Center for Health Statistics (NCHS) Hyattsville, Maryland.

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ADVANCE® Nutritional Beverage
For milk-sensitivity
ISOMIL® Soy Protein Formula

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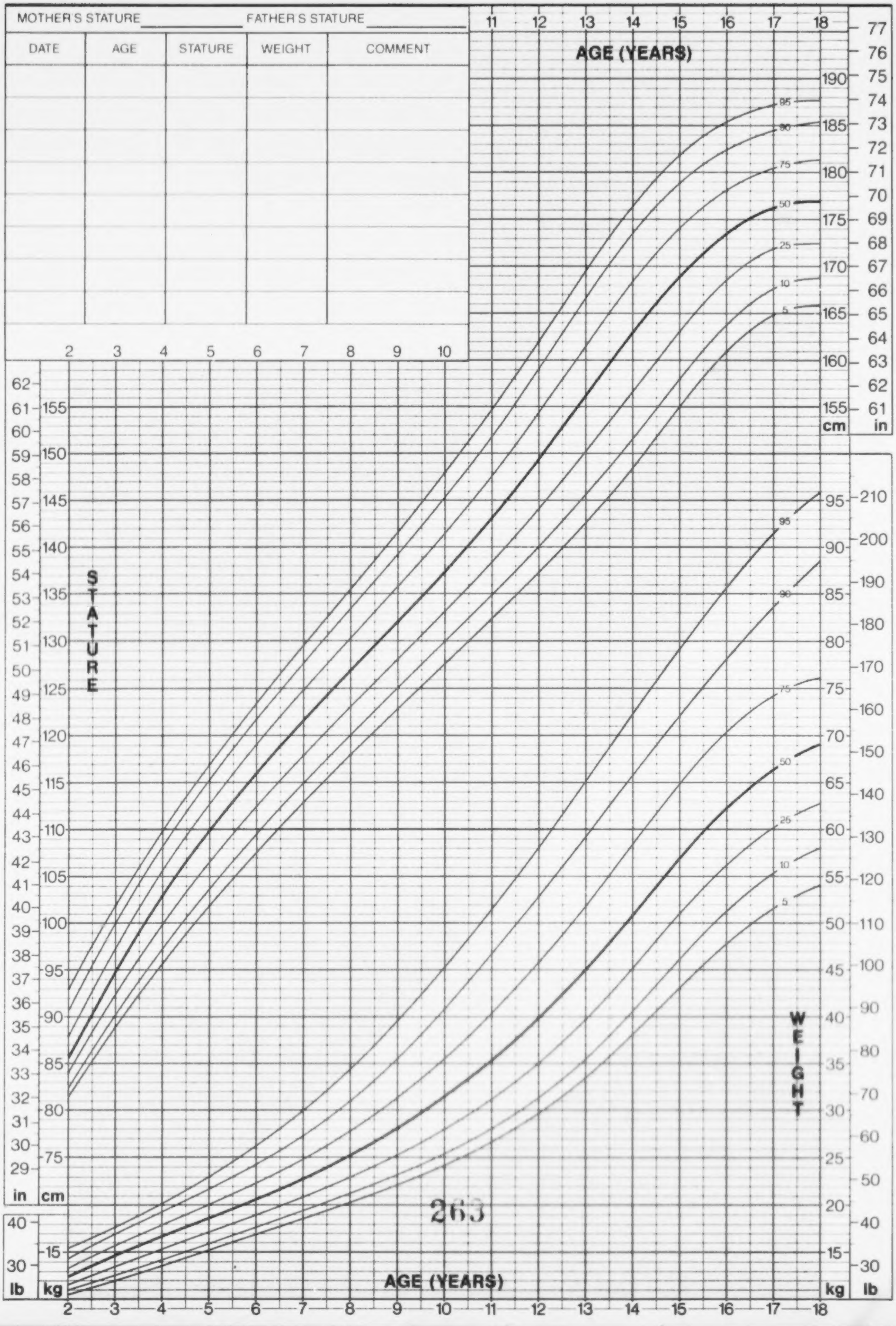
DIVISION OF ABBOTT LABORATORIES USA
G108/JUNE 1982

BOYS: 2 TO 18 YEARS
PHYSICAL GROWTH
NCHS PERCENTILES*

NAME ______________________________ RECORD # ______________

MOTHER'S STATURE ____________ FATHER'S STATURE ____________

DATE	AGE	STATURE	WEIGHT	COMMENT



Ross Growth & Development Program

*Adapted from: Hamill PVV, Drizd TA, Johnson CL, Reed RB, Roche AF, Moore WM: Physical growth: National Center for Health Statistics percentiles. AM J CLIN NUTR 32:607-629, 1979. Data from the National Center for Health Statistics (NCHS) Hyattsville, Maryland.

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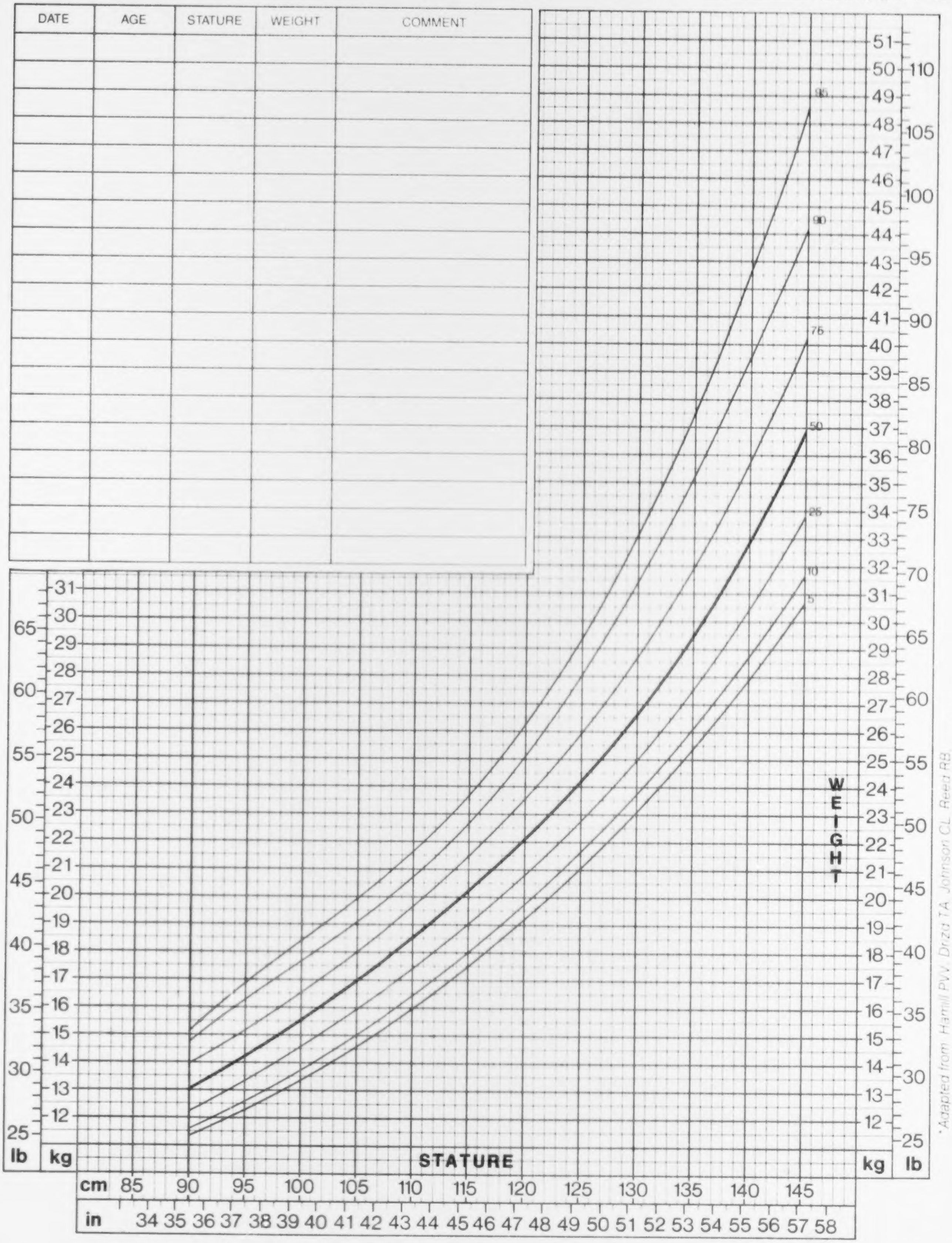
BOYS: PREPUBESCENT PHYSICAL GROWTH NCHS PERCENTILES*

NAME ______________________ RECORD # ________

DATE	AGE	STATURE	WEIGHT	COMMENT



*Adapted from: Hamill PVV, Drizd TA, Johnson CL, Reed RB, Roche AF, Moore WM: Physical growth: National Center for Health Statistics percentiles. AM J CLIN NUTR 32:607-629, 1979. Data from the National Center for Health Statistics (NCHS), Hyattsville, Maryland

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Preferable to cow milk during the first year
SIMILAC® WITH IRON
Infant Formula
ADVANCE®
Nutritional Beverage
For milk-sensitivity
ISOMIL®
Soy Protein Formula

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COLUMBUS, OHIO 43216
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